9718 JAN 19 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38123

1. DECEASED NAME (TYPE OR PRINT) FIRST: FREDERICK	MIDDLE: Lewis	LAST: SHARPS	2a. DATE OF DEATH MONTH DAY YEAR: December 20, 1988	2b. HOUR: 12:05 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 31, 1925	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Partner	12b. KIND OF BUSINESS OR INDUSTRY: Auto Sales	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD	Garrett	Oakland	YES ☐ NO ☒	P.O. Box 207	21550

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Clarence	Edward	Sharps	Gertrude	Lena	Shafferman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		212-24-2132	Mrs. Marion D. Sharps, See #13 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction WITH Cardiogenic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b): abdominal aorta [redacted] occlusive disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): Bilateral external iliac artery occlusion

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
12/14/88	[redacted] BILATERAL ILIAL ART. OCCLUSIONS	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~the hospital~~) attended the deceased from 12/13, 19 88, to 12/20, 19 88, that (I) (we) last saw the deceased alive on 12/19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~ did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1-__-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Philip Schroeder	Memorial Hospital Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	12/22/88	Garrett Co. Mem. Gardens	Oakland, Garrett, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradley A. Stewart	Oakland, Maryland 21550	DEC 23 '88	Julia Davidson-Randall

016263 DEC 15 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38129

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Anna	Barbara	Boston (Klingler)

2a. DATE OF DEATH: MONTH December DAY 12 YEAR 1988 — 2b. HOUR 1:00 A.M.

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 08 DAY 09 YEAR 21 — 6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARITAL: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Anne Arundel County MD.

10. CITY OR TOWN OF DEATH: Severn — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1417 Larch Road — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housework — 12b. KIND OF BUSINESS OR INDUSTRY: At Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: A.A. — 13c. CITY OR TOWN: Severn — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 1417 Larch Road 21144

14. FATHER'S NAME	FIRST	MIDDLE	LAST
	Herdman		Nelson

15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST
	Marie		Zorn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ---------- — 16b. SOCIAL SECURITY NO.: 215-16-0217 — 17. INFORMANT ADDRESS: Pearl E. Wolfe 639 S. Lehigh St. 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ventricular Fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: min

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure — 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Angina — 15 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES ☐ NO ☐ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I (this hospital) attended the deceased from 12 19 87 to 19 88, that (I) (we) last saw the deceased alive on 12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 12/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Raymond Bahr — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12-15-88 — 23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery — 23d. LOCATION CITY OR TOWN: Eastwood — COUNTY: Balto Co. — STATE: Md.

24. FUNERAL DIRECTOR NAME: Charles S. Zeiler & Son Inc. — ADDRESS: 6224 Eastern Ave.

25a. DATE REC'D BY REGISTRAR: DEC 14 1988 — 25b. REGISTRAR'S SIGNATURE

015809 DEC 12 88

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38130
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: LAST: Chapman			2a. DATE OF DEATH MONTH DAY YEAR: 12 - 4 - 88	2b. HOUR: 7: PM	
3. SEX: Male	4. RACE: B	5. DATE OF BIRTH MONTH DAY YEAR: 7 24 99	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Anne Arundel Cty MD.		
10. CITY OR TOWN OF DEATH: Millersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Knollwood Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Painter	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	A.A.	District Heights	YES ☐ NO ☐	1917 Tenaw Place

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Frank Chapman	Susan Allen	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-12-7025	John Chapman Jr.	965 Franklin Manor Crownsville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary hemorrhage	
DUE TO, OR AS A CONSEQUENCE OF (b)	Cancer lung	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-2 19 88 to _____ 19 _____, that (I) (we) last saw the deceased alive on 12-2 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Carl S Rhodes MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12 6 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/8/88	Moses Cem.	Drury A.A. Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Reese & Sons Mortuary Annapolis Md 21401	DEC 7 - 1988	Linda Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

021011 JAN 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38131

REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
ANNE	C.	HATFIELD	12	31	88 / 12:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Caucasian	Oct. 16, 1914	74 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New Jersey	United States		ANNE ARUNDEL Co MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Annapolis	Anne Arundel General Hsp	Banker	Banking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
New Jersey		Emerson	YES ☒ NO ☐	24 Mitchell Street/07630

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James		Clinton	Catherine		Cassatalline

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		088-07-1902	Peter L. Hatfield	2903 Spring Lake Drive Davidsonville, MD 21035

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BRAIN ANOXIA

DUE TO, OR AS A CONSEQUENCE OF (b) CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Pancreatic Carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ~ 2yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER, 19 88, to DECEMBER 31, 19 88, that (I) (we) last saw the deceased alive on 12/1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
	MD	☒	12/31/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ANDREW G. GORDON	16 Murray Ave ANNAPOLIS Md 21041

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	12/31/88	Metropolitan Crematory	Alexandria, Fairfax, VA

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A.	16000 Annapolis Rd. Bowie, MD 20715	JAN 27 1989	Sylvia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

015940 DEC 13 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 038132
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soto.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Kathleen Elizabeth Kardatzke		2a. DATE OF DEATH MONTH DAY YEAR	12-6-88
			2b. HOUR	704PM
3. SEX	Female			
4. RACE	White			
5. DATE OF BIRTH MONTH DAY YEAR	5-23-50			
6. AGE (IN YEARS LAST BIRTHDAY)	38 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Illinois			
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.			
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐				
9. BALTIMORE CITY OR COUNTY OF DEATH	Anne Arundel MD.			
10. CITY OR TOWN OF DEATH	FT. Meade, MD			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Kimbrough Army Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife			
12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE	MD			
13b. COUNTY	AA			
13c. CITY OR TOWN	Severn			
13d. INSIDE CITY LIMITS? YES ☐ NO ☒				
13e. STREET ADDRESS	1906 Cuire Drive 21144			
14. FATHER'S NAME FIRST / MIDDLE / LAST	Kenneth Francis Tabaka			
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Kathleen Morris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	n/a			
(IF YES, GIVE WAR OR DATES)	n/a			
16b. SOCIAL SECURITY NO.	349-44-9847			
17. INFORMANT ADDRESS	James Thomas, #13e			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Anoxic encephalopathy	4 Nov 88
DUE TO, OR AS A CONSEQUENCE OF (b)	cardiopulmonary arrests	4 Nov 88
DUE TO, OR AS A CONSEQUENCE OF (c)	aspiration pneumonitis	11 Nov 88
		4 Nov 88

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): multiple sclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Sabrina Benjamin	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	12-10-88	
23c. NAME OF CEMETERY OR CREMATORY	St. Joseph's Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE	Ivesdale	IL
24. FUNERAL DIRECTOR NAME / ADDRESS	Hardesty Funeral Home, 12 Ridgely Ave.	25a. DATE REC'D. BY REGISTRAR	DEC 12 1988	25b. REGISTRAR'S SIGNATURE: Tinderson Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0163'61 Dec 15 88

1 - FOR STATE REGISTRAR

REG. NO. 88 133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
GEORGE		SPRIGGS, JR.	12	2	1988	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
M	NEG	7 2 68	20 YRS.			12 2 1988	0315
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	usa		AA MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
LOTHIAN	STREET	Prof. Baseball Player					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	AA	Lothian	YES ☐ NO ☒	336 West Bay Front 20711

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George		Spriggs, Sr.	Alice		Contee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		216-06-0230	George Spriggs, Sr.	336 West Bay Front Rd. Lothian, Md. 20711

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8199

IMMEDIATE CAUSE (a) Severe Head Trauma

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Motor Vehicle Accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE William P. Jones, MD M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-2-88

EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. ADDRESS 695 America Court 21035

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	12-7-88	Spriggs Cemetary	Dunkirk,	Calvert Co.,	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Spencer E. Sewell	1451 Dares Beach Rd. Prince Frederick, Md. 20678	JAN 9 1989	Julia Davidson-Randall

07/84 25M BP 6

DHMH - 17 (VR A15 ME (5))

016138 DEC 14 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. 88 39134

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Anna	M.	Bartlett	December 9 1988	2:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Feb. 7 1892	96 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Baltimore County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Towson	Meridian Cromwell N. H.	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.		Balto.	YES ☒ NO ☐	2640 McKewin Ave. 21218

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Peter		Miller		Unknown	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		216-46-2406	Robert B. Bartlett	Balto., Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lower GI bleeding — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Congestive Heart failure, Malnutrition, Dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-3, 1988, to 12-9, 1988, that (I) (we) last saw the deceased alive on 12-9, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Carl Sperling M.D.	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-10-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Carl Sperling M.D.	1501 E. Belvedere Ave. Balto., Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-12-88	Woodlawn	Woodlawn Balto. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Henry W, Jenkins & Sons	4905 York Rd. Balto., Md.	DEC 12 1988	Madison Mandell

019774 JAN 19 19 — 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38136 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove perforated pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	BLANCHE / A. / DORFLER	2a. DATE OF DEATH — MONTH DAY YEAR	]1-06-88	2b. HOUR	]:30A M
3. SEX	FEMALE	4. RACE	WHITE	5. DATE OF BIRTH — MONTH DAY YEAR	09 27 90
6. AGE (IN YEARS LAST BIRTHDAY)	98 YRS	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	BALTIMORE COUNTY MD				
10. CITY OR TOWN OF DEATH	TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	GBMC 6701 NORTH CHARLES STREET	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	R.N.
12b. KIND OF BUSINESS OR INDUSTRY	Nursing				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Baltimore	Baltimore	YES ☐ NO ☒	908 Regester Ave. 21239

14. FATHER'S NAME — FIRST / MIDDLE / LAST			15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST		
John	Thomas	Morgan	Carrie	Elizabeth	Bowen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
NO	----	212-17-5740	W.L.Dorfler 6410 Sherwood Road 21239

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asystole — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) MIOCARDIAL INFARCTION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE	22c. DATE SIGNED
Jackie Syme M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	]1-06-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JACKIE SYME M.D.	GBMC 6701 NORTH CHARLES STREET

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	11-9-88	Prospect Hill	Towson / Balto. / Md.

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld Home 6500 York Road 21212	NOV 10 1988	[illegible] Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

020483 JAN 25 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38136
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	GEORGE B. LEAVY	2a. DATE OF DEATH MONTH DAY YEAR	12 27 88	2b. HOUR	21.40 PM
3. SEX	Male	4. RACE	Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	6-30-1924
6. AGE (IN YEARS LAST BIRTHDAY)	64 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Baltimore County MD.				
10. CITY OR TOWN OF DEATH	Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Baltimore County General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired-Casket Sales Rep.
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Carroll	13c. CITY OR TOWN	Woodbine
13d. INSIDE CITY LIMITS? YES [ ] NO [X]		13e. STREET ADDRESS	7651 Woodbine Rd. 21797		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Fred B. Leavy	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Zana Brett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	WW 2 159-24-0539	17. INFORMANT	Mary Jane Leavy
ADDRESS	Woodbine MD 21797 7651 Woodbine Rd. Box 285				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic CA of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (X) this hospital) attended the deceased from 12/19 19 88 to 12/27 19 88 that I (we) lost saw the deceased alive on 12/29 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	Young J. Ro MD	DEGREE ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	22c. DATE SIGNED 12/29/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Young J. Ro	22e. ADDRESS	B. C. G. H

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	1-2-89	23c. NAME OF CEMETERY OR CREMATORY	Hillcrest Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Clearfield Clearfield Penn				
24. FUNERAL DIRECTOR NAME / ADDRESS	Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133	25a. DATE REC'D. BY REGISTRAR	JAN 24 1989	25b. REGISTRAR'S SIGNATURE	

17856 DEC -3 09

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 3 8 1 3 7 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
EWALD	F.	SCHULZE	12-24-88	1:15A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	WHITE	12-05-09	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Germany	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
TOWSON	GBMC-6701 NORTH CHARLES STREET	Accountant	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Baltimore	Baltimore	YES [ ] NO [X]	317 Dunkirk Rd. 21212

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-01-8934	F.R. Gabler, Atty.	6600 York Rd. Baltimore, Md. 21212

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [XX]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-30, 19 88, to 12-24, 19 88, that (I) (we) last saw the deceased alive on 12-23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Nicholas Peter Georges	M.D.	STAFF PHYSICIAN [X]	12/24/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Nicholas Peter Georges	G.B.M.C. 6701 N. Charles St. Towson, MD 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 27, 1988	Dulaney Valley	Timonium, Baltimore, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld Home, Inc.	6500 York Rd. Balto, Md. 21212	DEC 28 1988	Julia Davidson-Pondelle

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

021152 JAN 31 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 338133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: mary Middle: M. Last: Weber				2a. DATE OF DEATH Month Day Year: 12 06 88	2b. HOUR: 0913 A M
3. SEX: F	4. RACE: White	5. DATE OF BIRTH Month Day Year: 5 14 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore Co. MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Baltimore Co. Gen. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY: Bank		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Randallstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 9109 Liberty Rd.	21133
14. FATHER'S NAME First: Theodore Middle: Last: Yeiser		15. MOTHER'S MAIDEN NAME First: Mary Middle: Last: Essich			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-24-0453	17. INFORMANT: Margaret A. Lambert	ADDRESS: 5312 Augusta St. Bethesda, Md. 20816		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (c): coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hx of Myocardeal Infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9/14 19 88 to 12/6 19 88, that (I) (we) last saw the deceased alive on 11/30 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: T. Kawaja DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/6/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TAHOORA KAWAJA — 22e. ADDRESS: 5310 Old Court Rd. Randallstown MD 21133

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-9-88	23c. NAME OF CEMETERY OR CREMATORY: Krider's Cemetery Westminster	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Carroll Md.

24. FUNERAL DIRECTOR (SIGNATURE AND ADDRESS): Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Md. 21157 — DATE RECEIVED BY REGISTRAR: DEC 12 88 — REGISTRAR: [illegible]

020004 JAN 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38139 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Jasper [redacted] Middle: [redacted] Last: Allen, Jr.

2a. DATE OF DEATH Month Day Year: 12-11-88

2b. HOUR: 5:30 PM

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH Month Day Year: 12-04-36

6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mt Vernon Care Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): unemployed

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY:

13c. CITY OR TOWN: Baltimore

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 808 St. Paul 21202

14. FATHER'S NAME First Middle Last: Jasper Allen

15. MOTHER'S MAIDEN NAME First Middle Last: Rose Amos

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 219-32-2560

17. INFORMANT ADDRESS: William Allen-el

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE (a)): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Thrombosis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Alcoholism, Liver Disease, Drug Abuse, Korsakoff's Psychosis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 8 19 88, to Dec 11 19 88, that (I) (we) last saw the deceased alive on Dec 11 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Scott Rifkind

DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Scott Rifkind

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-19-88

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion

23d. LOCATION CITY OR TOWN Landsdown COUNTY STATE MD

24. FUNERAL DIRECTOR NAME: Irwin Carroll ADDRESS: 1712-14 W. North Ave

25a. DATE REC'D BY REGISTRAR: JAN 18 1989

25b. REGISTRAR'S SIGNATURE:

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual circumstance, the medical examiner must be notified at once

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward Items 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 7097 DEC 27 88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 8 3 3 1 4 0
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: Jones Hodges	LAST: Beard	2a. DATE OF DEATH MONTH DAY YEAR: 12/17/88	2b. HOUR OF DEATH: 9:05 AM	
3. SEX: F	4. RACE: B. 2	5. DATE OF BIRTH MONTH DAY YEAR: 6 04 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BALTimore	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore city MD.		
10. CITY OR TOWN OF DEATH: BALTimre	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harbor Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md	13b. COUNTY	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 3019 LaRue Square 21225

14. FATHER'S NAME FIRST: William	MIDDLE	LAST: Wiggins	15. MOTHER'S MAIDEN NAME FIRST: Lucy MIDDLE	LAST: Ballard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-03-0513	17. INFORMANT: Samuel Wright ADDRESS: 3019 LaRue Square

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Severe Dehydration, Azotemia
DUE TO, OR AS A CONSEQUENCE OF (c): Medical Bleed.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rheumatic mass.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/16/, 19 88, to 12/17/, 19 88, that (I) (we) last saw the deceased alive on 12/17/, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): N Bayliss	22e. ADDRESS: Harbor Hosp Center	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/22/88	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN: Anne Arundel / COUNTY / STATE: Md	
24. FUNERAL DIRECTOR NAME: Wm. C. March F/H	ADDRESS: West 4300 Wabash Avenue	25a. DATE REC'D. BY REGISTRAR: DEC 22 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rudolph	

DHMH - 16 50M 1/81 (VRA 15, 4)

019939 JAN 20-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38141
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, be sure to examiner must be notified or attended.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Allen	MIDDLE	LAST: Bowers	2a. DATE OF DEATH MONTH/DAY/YEAR: 12/25/88	2b. HOUR: 12:40 A.M.	
3. SEX: M	4. RACE: B. 2	5. DATE OF BIRTH MONTH/DAY/YEAR: 09/16/05	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): S. Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balto City MD.		
10. CITY OR TOWN OF DEATH: Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Levendale Hebrew Geriatric Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND		BALTO	YES ☑ NO ☐	2228 N. MONROE St 21217

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
CLEM / BOWERS	MARIA / ADLER	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	216109984	Mr William Davis	5819 Ethelbert St 21215

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiomyopathy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/3/88 to 12/25/88, that (I) (we) last saw the deceased alive on 12/25/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	12/25/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12-31-88	Mt Zion Cem	Balto Co. MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Per Joseph L. Russ	2222 W. North Ave	JAN 17 1989	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

017960 DEC-2-88 FOR STATE REGISTRAR Unknown 88-159

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. 36142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3-RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
CLIFTON		Broughton	12	13	88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
M	B	June 24 1967	21 YRS.			12-13-88	8:21P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.	U.S.		Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	University Hospital	Laborer					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Som.	Dames Quarter	YES ☐ NO ☒	c/o P.O. Dames Quarter Md.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LEE	C	Broughton	Anna	Bell	Rose

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		220-84-9801	Sylvia Handy - Upper Fairmount Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Closed head injury — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	6:26PM 12-12-88	Pedestrian struck by auto

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	street	Waverly Drive N. of Newton Street, Salisbury Wicomico Co., MD

22a. I certify that I took charge of the remains described above, held an Autopsy XXX ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XXX ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Marjorie Bell Lyle M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-14-88

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/22/88	Asher Pekr Cem.	Upper Fairmount Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hunting E. Ward Crisfield Md.	DEC 20 88	Julia Davidson-Randall

07/84 25M BP 2

DHMH - 17 (VR A15 ME (5))

Item # 8 Film G64 cg 1/25/89

019024 JAN 13 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38143 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
George	E.	Bryant Jr	12 28 88	2:01 am

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
male	black	11 29 1930	58 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
N.C.	U S A		Baltimore City MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Union Memorial Hospital	Disabled	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md		Baltimore	YES ☒ NO ☐	4508 Garden Drive 21215

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	E.	Bryant, Sr	Etta	Lee	Fox

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes		241-32-2720	Mary Hines 4508 Garden Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	1/2 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	SEPSIS	4 days
DUE TO, OR AS A CONSEQUENCE OF (c)	PROBABLE HAEMORRHAGE	1 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (if this hospital) attended the deceased from 12/5/88 to 12/28/88, that (I) (we) last saw the deceased alive on 12/28/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dhayarous	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	12/28/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
	Union Memorial Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/4/89	Garrison Forest Vet	Owings Mills Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wm. C. March F/H	West 4300 Wabash Avenue	JAN 5 1989	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

019771 JAN 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 3 8 1 4 4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Juanita	MIDDLE	LAST: Burrow	2a. DATE OF DEATH MONTH DAY YEAR: 11/20/88	2b. HOUR: M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 2 16 28	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTO CITY MD.	
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 3714 Dolfield Ave. 21215
14. FATHER'S NAME FIRST / MIDDLE / LAST: Smith			15. MOTHER'S MAIDEN NAME FIRST: Exie MIDDLE: Lundy LAST:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 228-28-8667	17. INFORMANT ADDRESS: Robert Burrow 3714 Dolfield Ave. 21215	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b): Ø
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ø

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6/6 – 19 88 to 9/11 19 87 to current 19 89, that (I) (we) lost saw the deceased alive on 6/6 – 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M Brockington III	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11-21-88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Brockington, M.	22e. ADDRESS: 6776 Reisterstown Rd. # 211		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/25/88	23c. NAME OF CEMETERY OR CREMATORY: Family Cem.	23d. LOCATION CITY OR TOWN: Harrett	COUNTY: Virginia STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: Estep Bros. F. H. 1300 Eutaw Place		25a. DATE REC'D BY REGISTRAR: NOV 25 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Mondelle	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

019777 JA 19 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38145

1. DECEASED NAME (TYPE OR PRINT): FIRST ERNEST; MIDDLE F.; LAST DINISIO

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 23 YEAR 19 88 — 2b. HOUR M

3. SEX: MALE — 4. RACE: CAUC — 5. DATE OF BIRTH: MONTH 2 DAY 6 YEAR 19 — 6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 23 YEAR 19 88 — 2d. HOUR 11:35 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CARPENTER — 12b. KIND OF BUSINESS OR INDUSTRY: Globe Home Imp.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: Baltimore — 13c. CITY OR TOWN: Baltimore — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 1801 Tolson Ave 21222

14. FATHER'S NAME: FIRST RAPHAEL; MIDDLE ; LAST DINISO

15. MOTHER'S MAIDEN NAME: FIRST ; MIDDLE ; LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 220-12-4887

17. INFORMANT: MRS. VIRGINIA DINISIO — ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ M.D. — TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED 11-24-88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. — ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL: BURIAL — 23b. DATE: 11-28-88 — 23c. NAME OF CEMETERY OR CREMATORY: GARDENS OF FAITH — 23d. LOCATION CITY OR TOWN: Balto Co. COUNTY STATE: MD

24. FUNERAL DIRECTOR NAME: KACZOROWSKI F.H. — ADDRESS: 2525 Fleet St.

25a. DATE REC'D. BY REGISTRAR: NOV 29 1988 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING IN THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP _____ DHMH - 17 (VR A15 ME (5))

020430 JAN 24 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 338146
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: MELISSA	MIDDLE: [redacted]	LAST: KATINA FREEMAN	2a. DATE OF DEATH MONTH DAY YEAR: 12/7/88	2b. HOUR: 0200 A.M.		
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 12/5/86	6. AGE (IN YEARS LAST BIRTHDAY): — YRS	IF UNDER 1 YEAR MONTHS: — DAYS: 2	IF UNDER 24 HRS. HOURS: — MIN.: —	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.			
10. CITY OR TOWN OF DEATH: Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Agnes Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	P.G.	LANDOVER	YES ☒ NO ☐	7501 Allendale Dr. Landover MD. 20785

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
—	TRINESA — FREEMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Prematurity (23/24 weeks gest.)
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from —, 19—, to —, 19—, that (I) (we) last saw the deceased alive on 12/7/88 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☒	12/7/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C FAUS SANTOS	St. Agnes Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	1/18/89	NEW CATHEDRAL	BALTO., MD. 21229

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HUBBARD FUNERAL HOME WILKENS AVE BALTO., MD. 21229	JAN 19 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP—

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38147

2017.1 JAN 23 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: JESSIE; MIDDLE: L; LAST: GOVE
2a. DATE OF DEATH — MONTH: 12; DAY: 24; YEAR: 88
2b. HOUR: 1230 A M
3. SEX: F
4. RACE: W
5. DATE OF BIRTH — MONTH: 8; DAY: 26; YEAR: 23
6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CALIF.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: BALT. CITY MD.
10. CITY OR TOWN OF DEATH: BALT.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ST. AGNES HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CHEMIST
12b. KIND OF BUSINESS OR INDUSTRY: W.R. GRACE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD.
13b. COUNTY: HOWARD
13c. CITY OR TOWN: COLUMBIA
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 5686 STEVENS FOREST RD. 21045

14. FATHER'S NAME — FIRST: NORRIS; MIDDLE: D.; LAST: GOVE
15. MOTHER'S MAIDEN NAME — FIRST: MARION; MIDDLE: W.; LAST: SPRAGUE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): —
16b. SOCIAL SECURITY NO.: 207-16-1914
17. INFORMANT: LENA A. BECKETT
ADDRESS: 651 10th AVE. PROSPECT PARK PA. 19076

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary emphysema COPD
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/20 19 88 to 12/24 19 88, that (I) (we) last saw the deceased alive on 12/24 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: William J Hicken DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 12/26/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM J HICKEN, MD
22e. ADDRESS: St Agnes Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: 12-29-88
23c. NAME OF CEMETERY OR CREMATORY: BALT. WASH. CREM. INC.
23d. LOCATION — CITY OR TOWN: LAUREL; COUNTY: P.G.; STATE: MD.

24. FUNERAL DIRECTOR — NAME: STACK F.H. ADDRESS: PO BOX 268 E.C. 21043
25a. DATE REC'D. BY REGISTRAR: DEC 29 '88
25b. REGISTRAR'S SIGNATURE: Lena Davidson-Randall

IMPORTANT — TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and forwarded as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 20 20
DHMH-4630M 1/81 (VRA 15, 4)

020933 JAN 27 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 338143 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
WILLIAM	EUGENE	GRUMBINE	DECEMBER 16, 1988	10:00 A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	WHITE	NOV. 7 1912	76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD	USA		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			GARMENT INDUS.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	FREDERICK	WALKERSVILLE	YES ☐ NO ☒	8709 ADVENTURE AVE 21793

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	MARSHALL	GRUMBINE	EVA	A.	McCLAIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	217-10-0692	Susan Stone	8709 Adventure Ave., Walkersville, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio Vascular Arrest	30 min
DUE TO, OR AS A CONSEQUENCE OF (b)	Respiratory Arrest	30 min
DUE TO, OR AS A CONSEQUENCE OF (c)	Peripheral Vascular Disease	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
11/18/88	Peripheral Vascular Disease	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
	10:30 P.M. 12 16 1988	

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/18, 19 88, to 12/16, 19 88, that (I) (we) last saw the deceased alive on 12/16, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Timothy P. Codd	MD	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	12/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Timothy P. CODD	600 N. WOLFE ST Baltimore MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/20/88	MT. HOPE CEMETERY	WOODSBORO FREDERICK MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER, 1621 Opossumtown Pike, Frederick, MD 21701	DEC 21 1988	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 7 3 1 4 9

020 280

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN ☒ OF DEATH ESTIMATED ☐ MONTH	DAY	YEAR 19	2b. HOUR
Judith	Ann	Hill	12	20	88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19	2d. HOUR
Female	Black	3 07 1932	56 YRS.			12-20-88	10:50 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
N. Carolina	U. S. A.		Baltimore City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	613 Franklintowne Road	Domestic	Pvt. Family

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Baltimore	YES ☒ NO ☐	Maryland 21216 2656 Harlem Avenue, Baltimore,

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Francis		Parker	Emma		Hopkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		213-28-0976	Louis W. Hill Deborah Ann Minter	Baltimore, Maryland 616 Denison St. 21216

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

Chronic alcoholism

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-21-88

VC EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/28/1988	Garrison Forest Vet. Cem.	Baltimore, Maryland

24. FUNERAL DIRECTOR NAME NUTTER FUNERAL HOMES, INC. ADDRESS 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216

25a. DATE REC'D BY REGISTRAR JAN 19 1989 25b. REGISTRAR'S SIGNATURE Julia Davidson-Kinnear

R 07/8 25M

BP

DHMH - 17
(VR A15 ME (5))

019863 JAN 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 38150

DECEASED NAME (TYPE OR PRINT): FIRST Randolph MIDDLE Hoda LAST

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR 12-26-88 | 2b. HOUR M

3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 12-26-88 | 2d. HOUR 2:25 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. | 13b. COUNTY | 13c. CITY OR TOWN: BALTIMORE | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 1909 E. Eager St. 21205

14. FATHER'S NAME FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): UNK | (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-14-1222

17. INFORMANT ADDRESS: Mable Bazor-1302 Barclay Carrolton, Texas 75007

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Thermal injuries and smoke inhalation

8903

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 8PM 12-24-88 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): caught in - house fire

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): dwelling at

21f. LOCATION STREET CITY OR TOWN COUNTY STATE: Wolfe&Eager Streets Baltimore, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Colle Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 12-26-88

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Colle, Jr., M.D. ADDRESS: 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal | 23b. DATE: 1-5-89 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR: State Anatomy Board ADDRESS: Balto., Md.

25a. DATE REC'D BY REGISTRAR: JAN 9 1989 | 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

015820 DEC 12 881

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 338151
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21, 22 or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Hansford MIDDLE: T. LAST: Hoover		2a. DATE OF DEATH MONTH DAY YEAR: 12 06 88	2b. HOUR: 8404 M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 04 18 26	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harbor Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Painter
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: USA	13c. CITY OR TOWN: Edgemere	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 2705 Bowers Farm Road, Balto., Md. 21219
14. FATHER'S NAME FIRST: James M. MIDDLE: Hoover LAST:		15. MOTHER'S MAIDEN NAME FIRST: Bronia MIDDLE: White LAST:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO: 236-28-1895	17. INFORMANT — ADDRESS: Diana M. Phillips, 212 S. Bruce St., Balto., Md. 21223

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory - Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Multiple Myeloma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c): Hypercalcemia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/29 19 88 to 12/6 19 88, that (I) (we) last saw the deceased alive on 12/6 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Diana Feng — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 12/6/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Diana FENG — 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/9/88	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery	23d. LOCATION CITY OR TOWN: Baltimore City	COUNTY: STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Gary L. Kaufman, 5695 Main St., Elkridge, Md. 21227		25a. DATE REC'D BY REGISTRAR: DEC 08 1988	SIGNATURE: Julia Dandon-Andrea	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

019865 JAN 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38152
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bernice	MIDDLE: N.	LAST: Hynson	2a. DATE OF DEATH MONTH DAY YEAR: 11 9 88	2b. HOUR: M	
3. SEX: Female	4. RACE: Blk	5. DATE OF BIRTH MONTH DAY YEAR: 7 4 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balto. City MD.		
10. CITY OR TOWN OF DEATH: Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3618 Spaulding Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY	13c. CITY OR TOWN: Balto	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 3618 Spaulding Ave. (15)	
14. FATHER'S NAME FIRST: Willis	MIDDLE	LAST: Smith	15. MOTHER'S MAIDEN NAME FIRST: Cora	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO-PULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CARCINOMA OF ESOPHAGUS

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CORONARY ARTERY DISEASE ② HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6/21 19 85 to 11/9 19 88 that (I) (we) last saw the deceased alive on 10/1 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11/11/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 11-15-88	23c. NAME OF CEMETERY OR CREMATORY: King Mem PK	23d. LOCATION CITY OR TOWN: Randallstown	COUNTY / STATE: MD.
24. FUNERAL DIRECTOR NAME: Jeff Miller F.H.	ADDRESS: 1639 N. Broadway	25a. DATE REC'D. BY REGISTRAR: JAN 12 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH - 1660M 1/75
(VR A 15 (4))

19719 JAN 19 19

DIVISION OF VITAL RECORDS: 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED ON APPROVAL DR. KOKES PER MR. LAWYER

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 153

1a. DECEASED NAME (TYPE OR PRINT): FIRST BETTY; MIDDLE Ruth; LAST ISABEL

2a. DATE OF DEATH: MONTH DECEMBER; DAY 14; YEAR 1988

2b. HOUR: 8:16 P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH June; DAY 21; YEAR 1943

6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS: HOURS; MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH: BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife/Aide

12b. KIND OF BUSINESS OR INDUSTRY: Home/Nursing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Garrett

13c. CITY OR TOWN: Deer Park

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt. 4, Box 230-A 21550

14. FATHER'S NAME: FIRST Glenn; MIDDLE Ralph; LAST Guthrie

15. MOTHER'S MAIDEN NAME: FIRST Grace; MIDDLE Pearl; LAST Sisler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-40-4058

17. INFORMANT ADDRESS: Samuel F. Isabel, Wells, ME 04090

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO, OR AS A CONSEQUENCE OF (b): variceal hemorrhage — 1 hr

DUE TO, OR AS A CONSEQUENCE OF (c): hepatic failure — 24 hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary hypertension, Portal hypertension, Chronic active hepatitis

19a. DATE OF OPERATION: 12/14/88

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hepatic failure

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 88 to 12/14 19 88, that (I) (we) last saw the deceased alive on 12/14 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. Lee MD

DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 12/14/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Andrew Lee

22e. ADDRESS: Johns Hopkins Hospital, Baltimore, MD 21205

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial

23b. DATE: 12/18/88

23c. NAME OF CEMETERY OR CREMATORY: Rodeheaver Cemetery

23d. LOCATION: CITY OR TOWN Oakland; COUNTY Garrett; STATE Maryland

24. FUNERAL DIRECTOR: NAME Bradley A. Stewart; ADDRESS Oakland, Maryland 21550

25a. DATE REC'D. BY REGISTRAR: DEC 23 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked, item 18 shows injury, poisoning, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

3 2255 14 68

ISABEL, BETTY R 06722743

R BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 33154

016290 DEC 5-88

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANNIE MIDDLE: B LAST: JACKSON

2a. DATE OF DEATH MONTH DAY YEAR: 12 1 88 | 2b. HOUR: M

3. SEX: Female | 4. RACE: Black | 5. DATE OF BIRTH MONTH DAY YEAR: 03 23 04 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.

10. CITY OR TOWN OF DEATH: Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Ends of Evergreen Nes Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: 0

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: | 13c. CITY OR TOWN: Baltimore | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 2717 Cassen Ave 21215

14. FATHER'S NAME FIRST MIDDLE LAST: Mitch Byrd | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Sally Byrd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 241545249 | 17. INFORMANT ADDRESS: Mrs Gloria Jackson 2717 Cassen Ave 21215

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Anemia / Sepsis / HTN D

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (~~this hospital~~) attended the deceased from 15 Sept 88 to 1 Dec 88 that ~~I~~ (we) last saw the deceased alive on 1 Dec 88, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 12-7-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arthur N. Lebson MD | 22e. ADDRESS: 3640 Fords Lane

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-5-88 | 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE: A.A. Co. Md

24. FUNERAL DIRECTOR NAME ADDRESS: Joseph L. Russ 2222 N. North Ave | 25a. DATE REC'D. BY REGISTRAR: DEC 14 1988 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows that injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

19691 JAN 9 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38155 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST B/G	MIDDLE	LAST JACKSON	2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 88	2b. HOUR 1:17 AM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS — DAYS —	IF UNDER 24 HRS. HOURS 1 MIN. —
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? MD	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md	13b. COUNTY Mont	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE 3380 Hillcrest and Curtis Dr	Apt 304 20902
14. FATHER'S NAME FIRST BERNARD	MIDDLE	LAST JACKSON	15. MOTHER'S MAIDEN NAME FIRST ROBIN	MIDDLE	LAST JACKSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEVERE AIR LEAK SYNDROME

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY DISTRESS SYNDROME

DUE TO, OR AS A CONSEQUENCE OF (c) PREMATURITY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 12-12, 19 88, to 12-13, 19 88, that (I) (we) last saw the deceased alive on 12-13, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE E. CARTAYA	DEGREE ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 12/13/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. CARTAYA	22e. ADDRESS 4940 Eastern Ave Baltimore	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-21-88	23c. NAME OF CEMETERY OR CREMATORY FSKMC	23d. LOCATION CITY OR TOWN Balt	COUNTY Balt STATE MD
24. FUNERAL DIRECTOR NAME / ADDRESS FSKMC 4940 Eastern Ave Balt, MD 21224	25a. DATE REC'D. BY REGISTRAR JAN 17 1989	25b. REGISTRAR'S SIGNATURE Tina Davidson-Randall		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

POLICE MUNICIPALE

006717 SEP 9 88

FOR STATE REGISTRAR Add.info.perB.C. 9/27/88 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38156
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before signing.

BP_____

DHMH - 16 60M 7/84
(VRA 1S, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Maggie; MIDDLE: C.; LAST: ~~BABY GIRL~~ KOCHUKUNJAN				2a. DATE OF DEATH MONTH DAY YEAR: 3/1/88	2b. HOUR: 604 A.M.
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: 3/1/88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTO City		MD
10. CITY OR TOWN OF DEATH: BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ST Agnes Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Balto.	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 4429 Alan Dr., Apt. D 21229	
14. FATHER'S NAME FIRST: ~~CAITTILAPPI~~ Chillilappilly MIDDLE: LAST: KOCHUKUNJAN			15. MOTHER'S MAIDEN NAME FIRST: MATHIRI MIDDLE: C LAST: ~~KOCHUKUNJAN~~ Varghese		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Unknown
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NO OBVIOUS CONGENITAL ANOMALIES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☑ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James E Taylor	DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: 3/1/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES E TAYLOR	22e. ADDRESS: ST AGNES HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 3/22/88	23c. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL	23d. LOCATION CITY OR TOWN / COUNTY / STATE: BALTIMORE, MD. 21229	
24. FUNERAL DIRECTOR NAME: HUBBARD F. HOME	ADDRESS: WILKENS AVE. BALTO., MD. 21229	25a. DATE REC'D. BY REGISTRAR: MAR 23 1988	25b. REGISTRAR'S SIGNATURE: [signature]	

0 16597 DEC 19

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0 083 72 25

P

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #17; Film G646; 12/29/88; cdl

Item#13 Film#647 5-7 1/06/89 daa

FOR STATE REGISTRAR - 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LANCE	MIDDLE: RICHARD	LAST: LESESNE	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 12, 1988		2b. HOUR: 2:15 P M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: 3 15 1956	6. AGE (IN YEARS LAST BIRTHDAY): 32 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY		MD.
10. CITY OR TOWN OF DEATH: BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECURITY OFFICER	12b. KIND OF BUSINESS OR INDUSTRY: MD. NATIONAL BANK	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. ADDRESS
MARYLAND		BALTIMORE	YES [X] NO [ ]	626 629 E. 29TH ST. BALTIMORE, MD. 21218

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
UNKNOWN / UNKNOWN	SARAH / VERNELL / LESESNE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO, (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-64-5381	17. INFORMANT: ROMAINE LESESNE ADDRESS 626 629 E. 29TH ST. BALTO. MARYLAND 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	5 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	PRESUMED SEPSIS	14 hours
DUE TO, OR AS A CONSEQUENCE OF (c)	ACQUIRED IMMUNODEFICIENCY Syndrome	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Progressive Multifocal Leukencephalopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/25 19 88 to 12/12 19 88, that (I) (we) last saw the deceased alive on 12/12 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Howard R Mertz	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]	12/12/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
HOWARD R. MERTZ	TOWER 110 600 N. Wolfe St. Balto. MD. 21205 Johns Hopkins Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/17/1988	WOODLAWN CEM.	BALTIMORE, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
NUTTER FUNERAL HOMES, INC, 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216	DEC 15 1988	

019793 JAN 2 0 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

S B 38153
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Addie	MIDDLE: M	LAST: Long	2a. DATE OF DEATH MONTH: 12 DAY: 19 YEAR: 88	2b. HOUR: 6:48 P.M.	
3. SEX: F	4. RACE: B	5. DATE OF BIRTH MONTH: 04 DAY: 09 YEAR: 01	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deaton Hospital & Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY	13c. CITY OR TOWN: Balto	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 00000	
14. FATHER'S NAME FIRST: Andrew MIDDLE: [illegible] LAST: Jackson		15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: [illegible] LAST: Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-16-3812	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute cardiac arrest due to or as a consequence of: Pulmonary Edema	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~I~~ (this hospital) attended the deceased from 12/19 19 88 to 12/19 19 88, that ~~I~~ (we) last saw the deceased alive on 12/19 19 88, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [illegible] Gladue, MD.	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/19/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/22/88	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem	23d. LOCATION CITY OR TOWN: Glen Burnie / COUNTY / STATE: MD.	
24. FUNERAL DIRECTOR NAME: Jeff Miller F.H. 1659 N. Broadway		25a. DATE REC'D. BY REGISTRAR: JAN 12 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to release to Gladue by Deceased with Pacemaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with the least possible delay. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

015866 DEC 12 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 78152

1. DECEASED NAME (TYPE OR PRINT): FIRST ELLEN; MIDDLE; LAST RABB
2a. DATE OF DEATH: MONTH DECEMBER DAY 1 YEAR 1988
2b. HOUR 2:20A M
3. SEX: FEMALE
4. RACE: BLACK
5. DATE OF BIRTH: MONTH 7 DAY 14 YEAR 10
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH: BALTIMORE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): THE JOHNS HOPKINS HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House wife
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY:
13c. CITY OR TOWN: BALTIMORE
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 2220 BAKER STREET 21216

14. FATHER'S NAME: FIRST CHARLES MIDDLE W. LAST BYRD
15. MOTHER'S MAIDEN NAME: FIRST EILEEN MIDDLE R. LAST HARRIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN):
16b. SOCIAL SECURITY NO.:
17. INFORMANT: CHART ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO, OR AS A CONSEQUENCE OF (b): anoxia — 15 min
DUE TO, OR AS A CONSEQUENCE OF (c): adenocarcinoma — 5 yrs ≈
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: none

19a. DATE OF OPERATION: NA
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: NA
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 NA
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): NA
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/30 19 88 to 12/1 19 88 that (I) (we) last saw the deceased alive on 12/1 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Helen Collins DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 12/1/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Helen Collins
22e. ADDRESS: Johns Hopkins Hosp 600 N. WOLFE ST. Balt. MD 21205

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/6/88
23c. NAME OF CEMETERY OR CREMATORY: MD. NAT. MEM. PK.
23d. LOCATION: CITY OR TOWN Laurel; COUNTY Maryland; STATE
24. FUNERAL DIRECTOR: NAME E.L. Phillips ADDRESS 1721 W. Mount St.
25a. DATE REC'D. BY REGISTRAR: DEC 8 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other than natural manner must be reported at once to HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A burial, cremation or removal permit has been issued by the attending physician. Page 3 should be detached from page 2 before the certificate is completed. If not please remove. Page 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than natural manner must be reported at once to the local director, page 3 of this certificate must be completed and filed with the local registrar within 48 hours after death.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RABB, ELLEN

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked yes, attach a report of the injury, or other traumatic event, the medical examiner should be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38160

1. DECEASED NAME (TYPE OR PRINT): FIRST VIRGINIA MIDDLE LAST THOMPSON
2a. DATE OF DEATH: MONTH 11 DAY 13 YEAR 88
2b. HOUR 10:28 A.M.
3. SEX: FEMALE
4. RACE: BLACK
5. DATE OF BIRTH: MONTH 12 DAY 14 YEAR 17
6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: City MD.
10. CITY OR TOWN OF DEATH: BALTIMORE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): J.L. Dealton Hospital & Medical Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House wife.
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND
13b. COUNTY:
13c. CITY OR TOWN: BALTIMORE
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 00000

14. FATHER'S NAME: FIRST DANIEL MIDDLE LAST FREEMAN
15. MOTHER'S MAIDEN NAME: FIRST BESSIE MIDDLE LAST VENEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.
17. INFORMANT: CHART ADDRESS:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hours
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multiple CVAs Multiple decubiti D.M. Senile disorder COPD, Aspiration pneumonia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/7, 19 88, to 11/13, 19 88, that (I) (we) last saw the deceased alive on 11/13, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: C Hauta M.D. DEGREE: Resident — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 11/14/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gregory T. Harrington M.D.
22e. ADDRESS: Dealton Hosp. Balt. Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11/17/88
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMT
23d. LOCATION CITY OR TOWN: BALTIMORE COUNTY: MD. STATE:
24. FUNERAL DIRECTOR NAME: E.L. Phillips ADDRESS: 1721-27 N. MONROE STREET
25a. DATE REC'D BY REGISTRAR: NOV 18 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Ponder

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

J5332 AUG 26 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 33161

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Jessica	Middle: Lynn	Last: Wright	2a. DATE OF DEATH Month: 10	Day: 18	Year: 1987	2b. HOUR 6:20 AM
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month: 10	Day: 18	Year: 1987	6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.	IF UNDER 1 YEAR: Months 0, Days 0	IF UNDER 24 HRS: Hours 0, Min 8
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD				
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sinai Hospital of Balto.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Infant	12b. KIND OF BUSINESS OR INDUSTRY: N-A				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY	13c. CITY OR TOWN: Balto.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 2311 Elsinore Avenue			
14. FATHER'S NAME First: Michael	Middle: Anthony	Last: Wright	15. MOTHER'S MAIDEN NAME First: Tracey	Middle: Michele	Last: Salter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N-A	16b. SOCIAL SECURITY NO: N-A	17. INFORMANT: Medical Chart	ADDRESS			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: N-A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N-A	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10-18- 19 87 to 10-18- 19 87, that (I) (we) last saw the deceased alive on 10-18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Shari Sopher — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 8/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Shari Sopher — 22e. ADDRESS: Sinai Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY: Sinai Hospital	23d. LOCATION CITY OR TOWN: Baltimore	COUNTY	STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: N-A		25a. DATE REC'D. BY REGISTRAR: 12-22-88	25b. REGISTRAR'S SIGNATURE		

BP_____

DHMH-16 25M
(VRA 15, 4) 1/79

016950 DEC 22 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1a. FOR STATE REGISTRAR — REG. NO. 88-38162

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
JANE	E.	BAUGHER	12	19	88	0940 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	08	11	1897	91 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Md.	USA		Carroll MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	CARROLL CO. GENERAL HOSPITAL	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Balto.	Owings Mills	YES ☐ NO ☐	116 Gwynnbrook Ave. 21117

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	J	Hines	Jennie		Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-24-2510	Mrs. Betty Turnbaugh	SAA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	2-3 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Atrial Fibrulation	years
DUE TO, OR AS A CONSEQUENCE OF (c)	AS CVD	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GI Bleeding - hypoalbuminemia CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
12/13/88	GI Bleeding	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/16, 19 88, to 12/19, 19 88, that (I) (~~not~~) last saw the deceased alive on 12/19, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
John E. Steers	MD		12/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John E. Steers MD	Suite 102 Billingslea Bldg Westminster, Md 21157

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	12/21/88	Woodlawn Cemetery	Woodlawn	Balto	Md.

24. FUNERAL DIRECTOR NAME	POST	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eline Funeral Home	Reisterstown Md.	DEC 20 1988	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

020486 JAN 25 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 038163

1. DECEASED NAME (TYPE OR PRINT): FIRST Treva MIDDLE Louise LAST Hammond
2a. DATE OF DEATH: MONTH 12 DAY 29 YEAR 88
2b. HOUR: 10:45 A.M.
3. SEX: F
4. RACE: Cauc.
5. DATE OF BIRTH: MONTH 1 DAY 6 YEAR 10
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Carroll Co. MD.
10. CITY OR TOWN OF DEATH: Mt. Airy
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PLEASANT VIEW Nsg Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife
12b. KIND OF BUSINESS OR INDUSTRY: na

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD.
13b. COUNTY: Carroll
13c. CITY OR TOWN: Westminster
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 1706 Sykesville Rd. 21157

14. FATHER'S NAME: FIRST Hubert MIDDLE LAST Bitzel
15. MOTHER'S MAIDEN NAME: FIRST Gertrude MIDDLE LAST Frizzell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
16b. (IF YES, GIVE WAR OR DATES): na
16b. SOCIAL SECURITY NO.: 217-74-5878
17. INFORMANT: Kay Abbott, 2508 Karen Way ADDRESS: Westminster, Md. 21157

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MIN
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia — days
DUE TO, OR AS A CONSEQUENCE OF (c): PARKINSONS — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Aseid, CHF, Generic ischemic

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/20, 19 85, to 12/29, 19 88, that (I) (we) last saw the deceased alive on 12/15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Melvin Kordon DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/29/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Melvin Kordon MD
22e. ADDRESS: 2000 Century Plaza Columbia MD 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/31/88
23c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran
23d. LOCATION CITY OR TOWN: Smallwood COUNTY: Carroll STATE: MD

24. FUNERAL DIRECTOR NAME: Robert K. Pritts, Sr., ADDRESS: Westminster, MD
25a. DATE REC'D BY REGISTRAR: JAN 05 89
25b. REGISTRAR: Judith Davidson Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

021153 JAN 3 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38164
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Elbert	MIDDLE: James	LAST: Jorio	2a. DATE OF DEATH MONTH: 12 DAY: 5 YEAR: 1988	2b. HOUR: 8:30 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 7 DAY: 14 YEAR: 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balt., Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Carroll MD.		
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 908 Wampler Lane	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Hairstylist	12b. KIND OF BUSINESS OR INDUSTRY: Beauty Salon		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Carroll	Westminster	YES [X] NO [ ]	908 Wampler Lane 21157

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Vincent	J.	Jorio	Margaret	E.	Meinecke

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-18-3279	Isabelle S. Jorio	(same as above 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE

DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PARKINSON'S DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/24, 19 86, to 12/5, 19 88, that (I) (we) last saw the deceased alive on 10/13/88, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Howard G. Lanham MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/5/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
HOWARD G. LANHAM, MD	215 WASHINGTON AVE, WESTMINSTER

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-8-88	Moreland Memorial Park Cemetery	Baltimore / Baltimore Md.

24a. FUNERAL DIRECTOR	24b. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Thomas D. Fletcher & Son Funeral Home, 254 East Main Street, Westminster, Md. 21157	DEC 7 '88	Julia Davidson-Randall

BP 6

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 88 38165

020941 JAN 20 89

1. DECEASED NAME (TYPE OR PRINT): FIRST Minnie MIDDLE R. LAST ROUTZHAN
2a. DATE OF DEATH: MONTH 12 DAY 22 YEAR 88
2b. HOUR: 435 A.M.
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH FEB. DAY 28 YEAR 1901
6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: CARROLL MD.
10. CITY OR TOWN OF DEATH: MT. AIRY
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PLEASANT VIEW NURSING HOME
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: FREDERICK
13c. CITY OR TOWN: FREDERICK
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 302 REDWOOD AVE., 21701

14. FATHER'S NAME: FIRST WILLIAM MIDDLE LAST TOMS
15. MOTHER'S MAIDEN NAME: FIRST ANNIE MIDDLE LAST BUHRMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): N/A
16b. SOCIAL SECURITY NO.: 220-10-5541D
17. INFORMANT: Esther M. Poffinberger ADDRESS: Frederick, MD 225 Wyngate Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senility.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 88 to 12-17 19 88, that (I) (we) last saw the deceased alive on 12-22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Arthur G. Andrews
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/22/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arthur G. Andrews, M.D.
22e. ADDRESS: 11801 Frightwood Rd. Mount Airy MD 21771

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 12/24/88
23c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEMETERY
23d. LOCATION CITY OR TOWN: MIDDLETOWN COUNTY: FREDERICK STATE: MD
24. FUNERAL DIRECTOR NAME AND ADDRESS: G. DOUGLAS STAUFFER 1621 Opossumtown Pike, Frederick, MD 21701
25a. DATE REC'D. BY REGISTRAR: DEC 21 1988
25b. REGISTRAR'S SIGNATURE: Gloria Mathison-Pinkett

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84 (VRA 15, 4)

017812 DEC 30 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33166
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Louis	P.	Burlin	December 14 1988	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	June 25 1920	68 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Cecil County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital of Cecil County	Transportation	Aberdeen Proving Ground

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Port Deposit	YES [ ] NO [X]	872 Principio Road 21904

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas	--	Burlin	Adeline	---	Veto

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-----	215-18-7310	Martha Tome Burlin	Port Deposit, Md. 21904

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Renal insufficiency.

DUE TO, OR AS A CONSEQUENCE OF (b) Acute M.I. CHF BPVD

DUE TO, OR AS A CONSEQUENCE OF (c) Acute CVA. Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [XX]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/5/10 (3) 19 87, to 12/14 19 88, that (I) (we) last saw the deceased alive on 12/14 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Jui-Chin Hsu	M D ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jui-Chin Hsu, M.D.	223 West Main St., Elkton, Md. 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec.17,1988	Hopewell Cemetery	Port Deposit Cecil Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Maryland	DEC 19 '88	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

HMH - 16 60M 7/84
(VRA 15, 4)

019776 JAN 18 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38167
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Walter	L.	Warnick	September 18, 1988		1:25A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	White	Aug 22 1916	72 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md	U. S. A		Cecil County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point	VETERANS ADMINISTRATION		Steel Worker	Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md	Allegany	Westernport	YES ☒ NO ☐	209 Walnut St.	21562
14. FATHER'S NAME FIRST / MIDDLE / LAST			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Walter W. Warnick			Ida Clara Merrill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. (IF YES, GIVE WAR OR DATES)	SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
Yes	Korea	217 07 6569	Miriam Wills	Westernport md	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Death
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Alzheimers Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ☒ (this hospital) attended the deceased from June 6, 1983 to September 18 1988, that (☒ (we) last saw the deceased alive on September 18, 1988, and that in ☒☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) ☒☒☒☒ view the body after death.

22b. SIGNATURE / DEGREE	ATTENDING PHYSICIAN ☒☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Fred Dressler, M.D.		9-18-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred Dressler	22e. ADDRESS VA Medical Center, Perry Point, MD. 21902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	9/26/88	Rest Lawn Park	Cumberland Allegany Md	
24. FUNERAL DIRECTOR NAME	ADDRESS		25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wayne Boak	Westernport 21562 Md		SEP 26 1988	J

018741 JAN 11 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38168
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy	MIDDLE: Ada	LAST: Koontz	2a. DATE OF DEATH MONTH DAY YEAR: December 27, 1988	2b. HOUR: 1149 AM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: OCT 27 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD.		
10. CITY OR TOWN OF DEATH: La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretery	12b. KIND OF BUSINESS OR INDUSTRY: D.C. Gov't		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Charles	White Plains	YES ☐ NO ☒	Rt. 2, Box 572/20695

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LOUIS		NAU	MARY		EVANS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		577 03 7513 A	JOSEPH KOONTZ	LA PLATA 28 TEAL COURT MD. 20646

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
n/a	n/a	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-27, 1988, to 12-27, 1988, that (I) (we) last saw the deceased alive on 12-12, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael A Leatherwood, MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-27-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael A. Leatherwood M.D.

22e. ADDRESS: P.O. Box 249 Waldorf md 20604

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 30, 88	TRINITY MEM. GARDENS	WALDORF / CHARLES / MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	p. O. Box 156 Waldorf, Md. 20604-0156	DEC 29 '88	Julia Davidson-Randall

R SP 10

RECEIVED
DEC 29 199
Charles County Public Dept.

019604 JAN 19 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 038169

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as above.

1. DECEASED NAME (TYPE OR PRINT) FIRST: EDNA	MIDDLE: Tulloss Earp	LAST: ORNOLD	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 30, 1988	2b. HOUR: 1:35P M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 28, 1917	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: CHARLES MD.		
10. CITY OR TOWN OF DEATH: LA PLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PHYSICIANS MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk Typist	12b. KIND OF BUSINESS OR INDUSTRY: County Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince Geo.	13c. CITY OR TOWN: Riverdale	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 5723 64th Place/20737	
14. FATHER'S NAME FIRST: Henry	MIDDLE: Arthur	LAST: Earp	15. MOTHER'S MAIDEN NAME FIRST: Lucy	MIDDLE: Dunnington	LAST: Tulloss
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): nO	(IF YES, GIVE WAR OR DATES): ---	16b. SOCIAL SECURITY NO.: 579-05-6793	17. INFORMANT: Nancy Richards	ADDRESS: 8012 Carbondale Way Springfield, Va. 22153	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/26, 19 88, to 12/30, 19 88, that (I) (we) last saw the deceased alive on 12/30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE WATHEN, M.D

22e. ADDRESS: LA PLATA, MARYLAND 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1-4-1989	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION CITY OR TOWN: Arlington / COUNTY: Arlington / STATE: VA	
24. FUNERAL DIRECTOR NAME: Huntt Funeral Home	ADDRESS: P. O. box 156 Waldorf, Md. 20604-0156	25a. DATE REC'D. BY REGISTRAR: JAN 05 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH - 16 50M 1/81 (VRA 15, 4)

018754 JAN 1 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38170 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before action.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Clarence	MIDDLE	LAST: Boles	2a. DATE OF DEATH MONTH DAY YEAR: 12 30 88	2b. HOUR: M	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 1 16 22	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): US	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: DORCHESTER MD.		
10. CITY OR TOWN OF DEATH: CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mallard Bay Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NOT KNOWN	12b. KIND OF BUSINESS OR INDUSTRY: NOT KNOWN		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Dorc.	Cambridge	YES ☒ NO ☐	Mallrd Bay Nursing Ctr. 21613

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
not known	not known

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		217-62-8597	Mallard Bay Nursing Home, Cambridge, M

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Multiple CVA's - Vegetative State
DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): HBP, Fever

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 82, to 12-30 19 88, that (I) (we) last saw the deceased alive on 12-22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Michael J Faddis MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michael J Faddis	302 Collins, Hurlock Md 21643

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1--3-89	Federal Hill Cem.	Federalsburg, Caroline, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Curran Funeral Home	308 High St. Cambridge, Md. 21613	JAN 10 1989	Julia Davidson-Mundell

019611 JAN 18 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

58 38171

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MARY	EUGENIA	BOSMAN	DECEMBER 11, 1988	1:00	P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JANUARY 14, 1922	66 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		DORCHESTER COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CAMBRIDGE	316 CRUSADER ROAD, APT. 202	BOOKKEEPER	FflorIST

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	DORCHESTER	CAMBRIDGE	YES [X] NO [ ]	316 CRUSADER ROAD, APT. 202/21631

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROBERT	G.	LOWE	ANNA	V.	MANNING

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
NO	-	218-12-1786	ALLEN NELSON, CAMBRIDGE, MD	RT. 1, BOX 99

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastic Carcinoma	mo
DUE TO, OR AS A CONSEQUENCE OF (b)	Squamous cell Carcinoma / Thyroid	Mo
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive Heart Failure A.S.C.V.D.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/15, 19 88, to 11/21, 19 88, that (I) (we) last saw the deceased alive on 11/25, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/13/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JOHN G. GREEN, M.D.	LOCUST AND QUINCY STREETS, SALISBURY, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12-13-88	EAST NEW MARKET CEM.	EAST NEW MARKET, DORCHESTER, MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631	JAN - 4 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

020734 JAN 26 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38172
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: GEORGE	MIDDLE: Dame	LAST: CAMPER	7a. DATE OF DEATH MONTH DAY YEAR: 12 - 17 - 88	7b. HOUR: 1:18 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov 25 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Dorchester County MD.		
10. CITY OR TOWN OF DEATH: Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dorchester General	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Programmer	12b. KIND OF BUSINESS OR INDUSTRY: State of NJ		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Dorchester	E. NewMarket	YES X NO ☐	304 Railroad Avenue/21631

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
FIRST Samual MIDDLE Wrightson LAST Camper	FIRST Lucy MIDDLE P. LAST Thompson	Yes / WWII	145-10-6703	Elinor B. Camper, East New Market, MD

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Small Cell Lung Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mo

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/22, 19 88, to 12/17, 19 88, that (I) (~~we~~) last saw the deceased alive on 12/17, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Craig W Caldwell	MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/17/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CRAIG W CALDWELL	DORCHESTER GEN. HOSP, CAMBRIDGE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-20-88	MD Eastern Shore Vet.	Beulah / Dorchester / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Zeller Funeral Home, East New Market, MD	JAN - 9 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

19619 JAN 18 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 3173

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Mary	Ellen.	Hastings	12-30-88	10:20 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	Caucasian	9 15 09	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Md Cambridge	USA		Dorchester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cambridge	Glasgow Nursing Home	buisness & Sales	Jewelry - Restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Dor.	Cambridge	YES ☒ NO ☐	311 Glenburn Ave. 21613

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	B.	Giliss	Blanche		Insley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		220-10-6871	Sister - Reg	Hubert Aspley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Stroke — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several hours.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis — 4 years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bullous Phemphigoid

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-22, 19 82, to 12-30, 19 88, that (I) (we) last saw the deceased alive on 12-30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Michael A. Moskewicz	M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-30-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL A. MOSKEWICZ M.D.	503 BRN ST. CAMBRIDGE 21613 MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
burial	1/2/89	LAUREL ODDFELLOWS	LAUREL	SUSSEX	DEL.

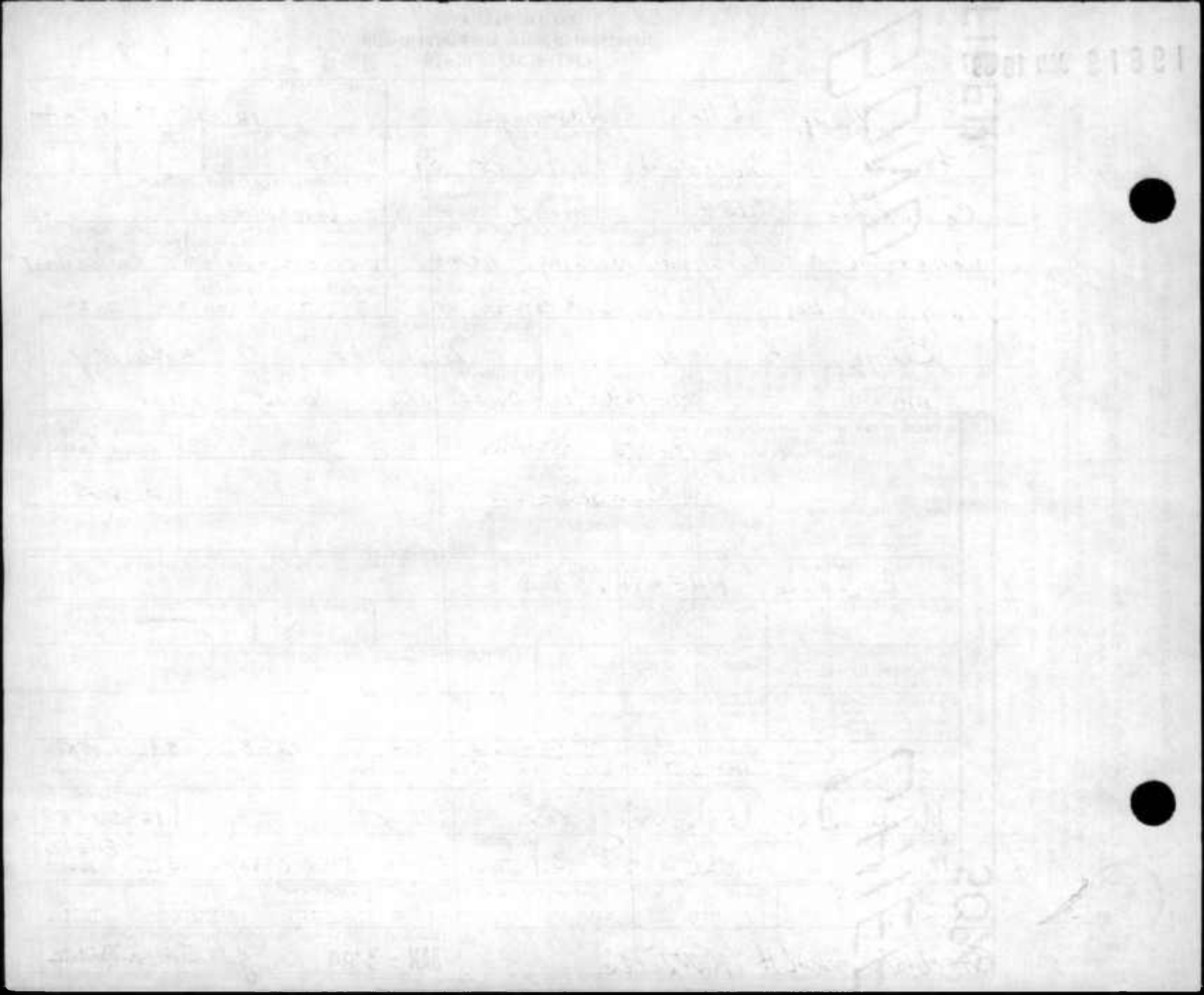
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
THOMAS FUNERAL H [illegible]	[illegible]	JAN - 3 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)



019603 JAN 10 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38174
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sadie	MIDDLE: I	LAST: Robinson	2a. DATE OF DEATH MONTH: 12	DAY: 26	YEAR: 88	2b. HOUR: 0625 PM
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH: May	DAY: 10	YEAR: 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Dorchester Co. MD.			
10. CITY OR TOWN OF DEATH: Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dorchester General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Cambridge	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS / ZIP CODE: 844 Park Lane / 21613		
14. FATHER'S NAME FIRST: James	MIDDLE: W.	LAST: Robinson	15. MOTHER'S MAIDEN NAME FIRST: Mattie	MIDDLE: S.	LAST: Ennals	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 228-05-4414	17. INFORMANT ADDRESS			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): INANITION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(b): METASTATIC ADENOCARCINOMA — MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): CARCINOMA OF OVARY — YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MASSIVE ASCITES, ANEMIA, PROBABLE SEPSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from 12-19, 19 88, to 12-26, 19 88, that (I) we) last saw the deceased alive on 12-24, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we) (did) did not) view the body after death.

22b. SIGNATURE: James F. McCarter — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 12-27-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES F. McCARTER, M.D. — 22e. ADDRESS: 400 AURORA STREET CAMBRIDGE, MD. 21613

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/29/88	23c. NAME OF CEMETERY OR CREMATORY: Bethel Cem.	23d. LOCATION CITY OR TOWN: Cambridge / COUNTY: Dor. / STATE: Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS: Stewart Funeral Home Cambridge Md.	25a. DATE REC'D. BY REGISTRAR: DEC 29 '88	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

020773 JAN 26 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38175

1. DECEASED NAME (TYPE OR PRINT): FIRST Catherine MIDDLE S. LAST Wongus
2a. DATE OF DEATH: MONTH 12 DAY 23 YEAR 88
2b. HOUR 229 PM
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: MONTH 03 DAY 20 YEAR 28
6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Dorchester MD.
10. CITY OR TOWN OF DEATH: Cambridge
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dorchester General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Food Processor
12b. KIND OF BUSINESS OR INDUSTRY: Food

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Dorchester
13c. CITY OR TOWN: Hurlock
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Rt. 1, Box 61B 21643

14. FATHER'S NAME: FIRST Samuel MIDDLE LAST Spicer
15. MOTHER'S MAIDEN NAME: FIRST Orealla MIDDLE LAST Conoway
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 213-22-8765
17. INFORMANT: Vanessa Dobson, ADDRESS PO Bx. 295, Hurlock Md. 21643

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO, OR AS A CONSEQUENCE OF (b): Massive CVA — 2 wks
DUE TO, OR AS A CONSEQUENCE OF (c): Dissecting Aneurysm — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertension

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from ____ 19____ to ____ 19____ that (I) (we) last saw the deceased alive on 12-23 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: M. Lee Keller MD DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1/10/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/28/88
23c. NAME OF CEMETERY OR CREMATORY: Linas Road Cemetery
23d. LOCATION: CITY OR TOWN Wingate, COUNTY Dorchester, STATE MD

24. FUNERAL DIRECTOR: NAME Framptom-Hawkins F.H., ADDRESS 216 N. Main St. Federalsburg
25a. DATE REC'D. BY REGISTRAR: JAN 13 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

020952 JAN 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP 15

DHMH - 16 SOM 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38176

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last	2a. DATE OF DEATH Month / Day / Year	2b. HOUR
HOWARD Kenneth BARKER	December 20 1988	0020 AM

3. SEX	4. RACE	5. DATE OF BIRTH Month / Day / Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	NOV. 23 1921	67 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		FREDERICK MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
FREDERICK	FREDERICK MEMORIAL HOSPITAL	PROCUREMENT OFR.	CIVIL SER.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	FREDERICK	FREDERICK	YES ☐ NO ☒	7716 BRIDLE PATH CIRCLE 21701

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
HOWARD C. BARKER	CLARA G. KELLEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	217-08-0455	HETTIE M. BARKER	FREDERICK, MD 7716 BRIDLE PATH CIRCLE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	respiratory arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	lung cancer metastatic to brain	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 16 19 88 to Dec 20 19 88, that (I) (we) last saw the deceased alive on Dec 19 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-20-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	12/21/88	SMITHSBURG CREMATORY	SMITHSBURG WASHINGTON MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER 1621 Opossumtown Pike, Frederick, MD 21701	DEC 21 1988	Julia Davidson-Randall

022047 FEB -8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38177 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Amos; MIDDLE: Franklin; LAST: Brown			2a. DATE OF DEATH — MONTH: 12; DAY: 26; YEAR: 88	2b. HOUR: 1845 P M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH — MONTH: MAY; DAY: 5; YEAR: 1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS	# UNDER 1 YEAR: MONTHS, DAYS; # UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD.	
10. CITY OR TOWN OF DEATH: FREDERICK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FRED. MEM HOSPTTOL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED-LAB. WORKER	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: FREDERICK	13c. CITY OR TOWN: FREDERICK	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 21701 192 WEST ALL SAINTS STREET
14. FATHER'S NAME — FIRST MIDDLE LAST: AMOS COLUMBUS BROWN			15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: CHARLOTTE JOHNSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): W.W. 1	16b. SOCIAL SECURITY NO: 214-16-6386	17. INFORMANT — ADDRESS: KATHERINE A. MOORE SAME AS 13 E	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prostate Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: year
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3-14-88, 1988, to 12-26, 1988, that (I) (we) last saw the deceased alive on 12-26, 19 88 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Allen J. Gilson MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allen J. Gilson — 22e. ADDRESS: 1425 TANEY AVE FRED MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 12-31-1988	23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW	23d. LOCATION — CITY OR TOWN, COUNTY, STATE: FREDERICK FRED. MD.
24. FUNERAL DIRECTOR — NAME, ADDRESS: C.E.HICKS 111 - 1922 FOREST DR. ANNA. MD. 21401	25. DATE REC'D BY REGISTRAR: JAN 09 1989	25a. REGISTRAR'S SIGNATURE: Jacqueline Davidson-Randall	

022253 FEB-3 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38173
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified (or other)

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARGARET	MIDDLE: ANN	LAST: BRUNNER	2a. DATE OF DEATH MONTH: DECEMBER	DAY: 30	YEAR: 1988
2b. HOUR: 12:10 AM					

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Nov. 3, 1907	81 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	Frederick County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frederick	Northhampton Manor Nursing Home	Cook	Fred. Mem. Hosp.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Frederick	Frederick	YES ☒ NO ☐	620 Trail Ave., 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Daniel		Brunner	Mamie		Weddle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	220-30-8973	Mrs. Mollie May 237 Wyngate Dr., Frederick, Md. 21701

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF (b) & Cong HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/14, 19 88, to 12/30, 19 88, that ~~I~~ (we) last saw the deceased alive on 12/29, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
George I. Smith Jr. M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. George I. Smith, Jr. MD	300 West Ninth St., Frederick, Md. 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Jan 3, 1989	Mt. Olivet Cemetery	Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701	JAN 03 1989	Julia Davidson-Randall

BP 2

DHMH - 16 60M 7/84
(VRA 15, 4)

XX

020953 JAN 30 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

12/84 25M BP

DHMH - 17
(VR A15 ME (5))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38179

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
HAZEL	N	Christian	12	16	19 88	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR
F	Cau	07	23	11	77 YRS.					12	16	19 88	1200 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
IOWA	USA		FREDERICK MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
FREDERICK	903 WILSON PLACE	DIETICIAN	GOVERNMENT

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
MD	FREDERICK	FREDERICK		903 WILSON PLACE 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CARL		CHRISTIAN	MARY		LARSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	220-26-2382	AMELIA GYLFEE	4119 EMERSON NORTH AVE. MINNEAPOLIS, MN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	
Conditions, if ony, which gave rise to immediate couse (a) stating the underlying couse last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE Robert R Roberts M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/16/88

EXAMINER'S NAME (TYPE OR PRINT) R R ROBERTS MD ADDRESS 15 W 7th Street Frederick MD 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	12/20/88	RESTHAVEN MEM. GARDENS	FREDERICK	FREDERICK	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER	1621 Opossumtown Pike, Frederick, MD 21701	DEC 21 1988	Julia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38180

02095 | JAN 30 88

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE Naomi LAST Coblentz
2a. DATE OF DEATH: MONTH Dec. DAY 20, YEAR 1988
2b. HOUR 6 P. M.
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH jan. DAY 26, YEAR 1898
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick Co. MD
10. CITY OR TOWN OF DEATH: Frederick
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meredian Nursing Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker
12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Frederick
13c. CITY OR TOWN: Middletown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 32 E. Main St. 21769

14. FATHER'S NAME: FIRST D. H. MIDDLE Oliver LAST Beachley
15. MOTHER'S MAIDEN NAME: FIRST Helen MIDDLE F. LAST Schildknecht
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 215-36-7245
17. INFORMANT ADDRESS: Austin Coblentz Jefferson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from many yrs. 19____, to 12/20/88 19____, that (we) last saw the deceased alive on 12/20/88 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: A. Austin Pearre Jr.
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/21/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. A. A. Pearre Jr.
22e. ADDRESS: Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/24/88
23c. NAME OF CEMETERY OR CREMATORY: Reformed Cemetery
23d. LOCATION: CITY OR TOWN Middletown COUNTY Fred. STATE Md.
24. FUNERAL DIRECTOR: Edward Hott Hott Funeral Home ADDRESS: Middletown Md. 21769
25a. DATE REC'D. BY REGISTRAR: DEC 21 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

R BP

DHMH - 16 60M 7/84
(VRA 15, 4)

020938 JAN 30 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38181
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Eleonore	MIDDLE: NMI	LAST: COOK	2a. DATE OF DEATH MONTH DAY YEAR: December 28, 1988	2b. HOUR: 4:33a M	
3. SEX: Female	4. RACE: Caucasion	5. DATE OF BIRTH MONTH DAY YEAR: July 5, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Algeria	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD.		
10. CITY OR TOWN OF DEATH: Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Frederick	13c. CITY OR TOWN: Frederick	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1417 Key Parkway East/ 21701	
14. FATHER'S NAME FIRST: Jean	MIDDLE	LAST: Rollo	15. MOTHER'S MAIDEN NAME FIRST: Marie	MIDDLE: C.	LAST: Manco
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): None	16b. SOCIAL SECURITY NO.: 167-24-9420	17. INFORMANT: John A. Cook, Jr.,	ADDRESS: 1417 Key Parkway East Frederick, Md. 21701	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	COPD	years
DUE TO, OR AS A CONSEQUENCE OF (b)	Cigaret Smoking	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Allen J. Gilson	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12-28-1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allen J. Gilson, M.D.		22e. ADDRESS: 1475 Taney Avenue, Frederick, Md. 21701	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Dec. 31, 1988	23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery	23d. LOCATION CITY OR TOWN: Philadelphia,	COUNTY: Phil.,	STATE: PA
24. FUNERAL DIRECTOR NAME: Keeney & Basford P.A. Funeral Home ADDRESS: 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR: DEC 28 1988	25b. REGISTRAR'S SIGNATURE: Julia Faidley-Pandazi		

BP 6

20950 JAN 30 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 33182

1. DECEASED NAME (TYPE OR PRINT) FIRST: Walter MIDDLE: (MI) LAST: CRUMMITT				2a. DATE OF DEATH MONTH DAY YEAR: December 19, 1988	2b. HOUR: 8:50 A.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 8, 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD.		
10. CITY OR TOWN OF DEATH: Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Farming	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Frederick	13c. CITY OR TOWN: Frederick	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 5817 Bartonsville Rd., 21701	
14. FATHER'S NAME FIRST: Jacob MIDDLE LAST: Crummitt			15. MOTHER'S MAIDEN NAME FIRST: Sally M. MIDDLE LAST: Tobery		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): None	16b. SOCIAL SECURITY NO.: 214-16-1940	17. INFORMANT: Dewey S. Crummitt, Jr.,	ADDRESS: 5817 Bartonsville Rd Frederick, Md. 21701	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Lung Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12-20-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. A. Majeed, M.D.		22e. ADDRESS: 801 Toll House Ave., Frederick, Md. 21701	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Dec. 22, 1988	23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR NAME: Keeney and Basford Funeral Home	ADDRESS: 106 East Church Street, Frederick, Md. 21701	25a. DATE REC'D. BY REGISTRAR: DEC 22 1988	25b. REGISTRAR'S SIGNATURE: [signature]	

DHMH - 16 50M 1/81 (VRA 15, 4)

020931 JAN 27 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38183
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
THELMA	MAE	ELLIS	DECEMBER 17 1988	3:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JUNE 22 1909	79 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MISSOURI	USA		FREDERICK MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
THURMONT	8132 ROCKY RIDGE ROAD	HOMEMAKER			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	FREDERICK	THURMONT	YES ☐ NO ☒	8132 ROCKY RIDGE ROAD, 21788

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CHARLES	FRANKLIN	WILLIS	MARTHA		JONES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	548-01-4542	Rachel Emrick	14002 Graceham Rd., Thurmont, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD | Coronary Artery Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	12/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
[illegible]	1475 Taney Ave

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/20/88	RESTHAVEN MEM. GARDENS	FREDERICK FREDERICK MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER, 1621 Opossumtown Pike, Frederick, MD 21701	DEC 21 1988	Julia Davidson-Randall

DP 7

DHMH - 16 60M 7/84 (VRA 15, 4)

020932 JAN 27 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38134
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	7a. DATE OF DEATH MONTH DAY YEAR	7b. HOUR
RUTH	NAOMI	FLICKINGER	DECEMBER 19, 1988	6:40A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	SEPT. 30 1900	88 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		FREDERICK MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
FREDERICK	FREDERICK MEMORIAL HOSPITAL	MANUFACTURING	RUBBER CO.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	FREDERICK	FREDERICK	YES ☒ NO ☐	105 W. 14th St., Frederick, MD 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
HARRY	WILLIAM	BOONE	MAGGIE		VALENTINE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	217-28-7154	Leroy Flickinger, 13645 Old Annapolis Rd.	Mt. Airy, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	15 min.
DUE TO, OR AS A CONSEQUENCE OF (b)	ASHD	10 years +
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Acute Abdominal Pain, cause undetermined

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from July 19 75, to Dec. 19 19 88, that (I) (we) last saw the deceased alive on Dec. 18 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
W. J. Riddick	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	12/19/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
W. J. RIDDICK, MD	Parkview Medical Center, Frederick, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/21/88	RESTHAVEN MEM. GARDENS	FREDERICK / FREDERICK / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER, 1621 Opossumtown Pike, Frederick, MD 21701	DEC 21 1988	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81 (VRA 15, 4)

020945 JAN 3 0 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38185 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ETHEL MIDDLE: SOPHIA LAST: GRIMES			2a. DATE OF DEATH MONTH DAY YEAR: December 22, 1988 — 2b. HOUR: 6:00 a M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: April 18, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD.
10. CITY OR TOWN OF DEATH: Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Shoe Factory Emp	12b. KIND OF BUSINESS OR INDUSTRY: None

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Thurmont	YES ☒ NO ☐	200 Old Emmitsburg Road/21788

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Shannon E. Grimes	Maggie I. Renner	No (IF YES, GIVE WAR OR DATES)	215-20-9727	Audrey Carpenter	5834 W. Chester Hills Ct. Eldersburg, Md. 21784

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Complete Left Bundle Branch Block 1 year

DUE TO, OR AS A CONSEQUENCE OF (b): and peripheral vascular disease, during years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital attended the deceased from 12/23 19 88 to 12/22 19 88 that (I) (we) last saw the deceased alive on 12/22 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-22-1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Casper E. Cline, III M.D.	300 West 9th St. Frederick, Md. 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-24-1988	Weller Cemetery	Thurmont, Frederick Co. Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R.E. DAILEY & SON, P.A.	615 East Main Street Thurmont, Md. 21788	DEC 23 1988	Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

0209 11 JAN 27 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38186
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Marie MIDDLE: P. LAST: Heatwole			2a. DATE OF DEATH MONTH DAY YEAR: January 23, 1989 — 2b. HOUR: 8:00P M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 31, 1921	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD.
10. CITY OR TOWN OF DEATH: Braddock Heights	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Vindobona Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Loan Processor — 12b. KIND OF BUSINESS OR INDUSTRY: Banking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Virginia	13b. COUNTY: Prince William	13c. CITY OR TOWN: Gainesville	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 375 High Court 99999

14. FATHER'S NAME FIRST: Marion	MIDDLE: Reynolds	LAST: Preston, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Marie MIDDLE: LAST: Sunderland

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 224-16-6596	17. INFORMANT ADDRESS: Stephanie Price — 375 High Court Gainesville, Va. 22065

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic disease

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from April 27, 19 88, to January 23, 19 89, that (I) (we) last saw the deceased alive on December 13, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒		22c. DATE SIGNED: 1/24/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Judith L Pasierb MD	22e. ADDRESS: 610 Ninth Ave. Brunswick MD 21716	

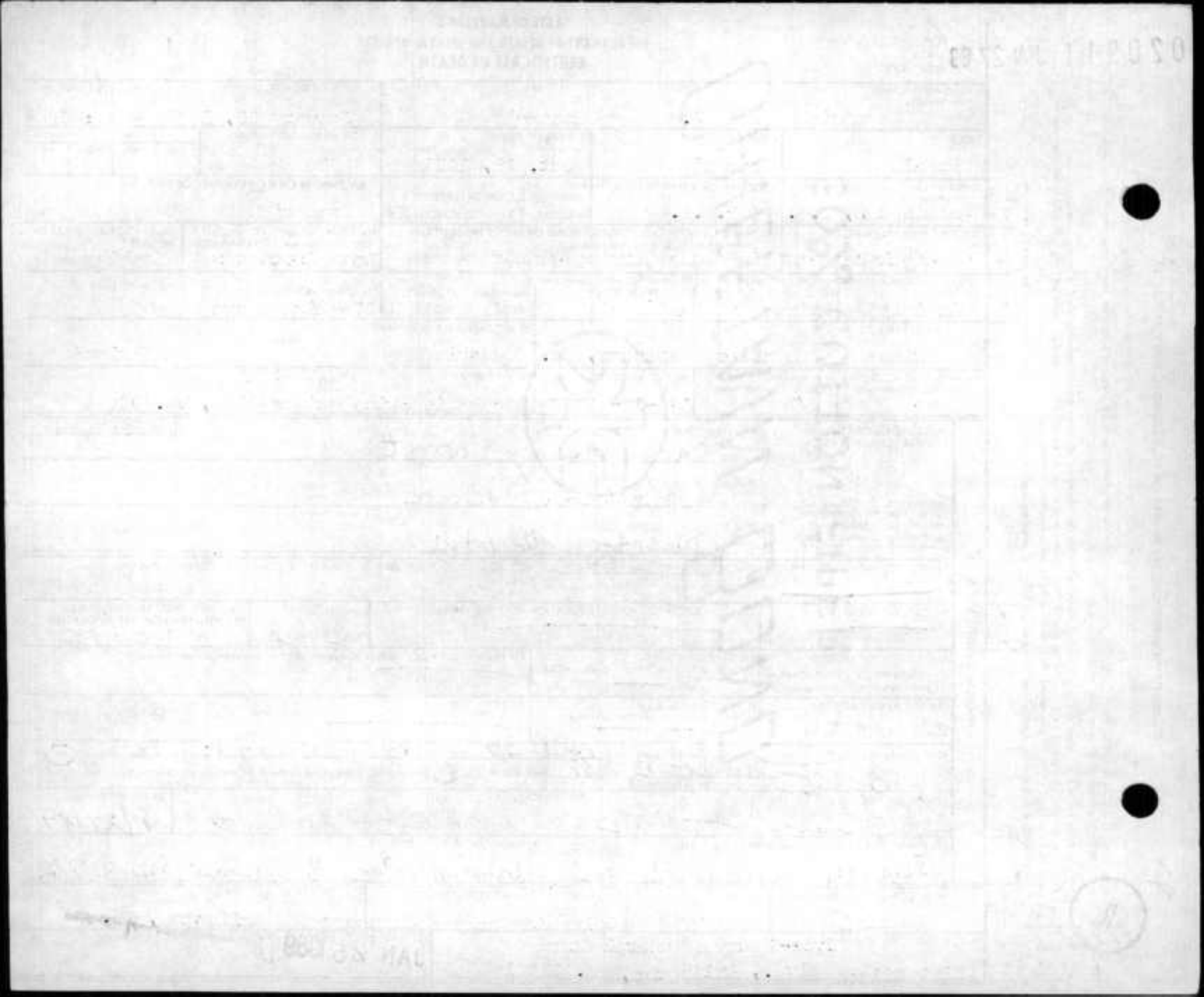
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/26/89	23c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington, Va.	
24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Home — ADDRESS: 2847 Wilson Blvd., Arlington, Va. 22201		25a. DATE REC'D BY REGISTRAR: JAN 26 1989	25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(Form) 16 25M (VR A 15 (4) 9/74)



022254 FEB-9 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 8 1 8 7
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): FIRST MARY VIRGINIA MIDDLE DRONEBURG LAST HEISER
2a. DATE OF DEATH: MONTH 12 DAY 30 YEAR 1988
2b. HOUR: 405 PM
3. SEX: FEMALE
4. RACE: Caucasian
5. DATE OF BIRTH: March 6, 1898
6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick MD.
10. CITY OR TOWN OF DEATH: Frederick
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Frederick
13c. CITY OR TOWN: Frederick
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 1192A N. Market St.

14. FATHER'S NAME: FIRST William MIDDLE U. LAST Droneburg
15. MOTHER'S MAIDEN NAME: FIRST Annie MIDDLE V. LAST Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 215-10-2497
17. INFORMANT: Mrs. Charlotte Brashears ADDRESS: 813 Trail Ave. Frederick, Md. 21701

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): FAILURE TO THRIVE
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): OSTEOPOROSIS

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE:

22a. I certify that (I) (this hospital) attended the deceased from 12/5/88 19____, to 12/31/88 19____, that (I) (we) last saw the deceased alive on not seen 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/31/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Richard L. Gough, MD R. GOUGH
22e. ADDRESS: 19 Frederick St., Walkersville, Md. 21793

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 1/3/89
23c. NAME OF CEMETERY OR CREMATORY: Linganore Meth.Ch. Cem.
23d. LOCATION: CITY OR TOWN Unionville, COUNTY Frederick, STATE Md.
24. FUNERAL DIRECTOR: Robert L. Dailey & Son 1201 N. Market St. Frederick, Md. 21701
25a. DATE REC'D. BY REGISTRAR: JAN 03 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

020934 JAN 20 89

1 - FOR STATE REGISTRAR

REG. NO. 33188

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH-3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Robert	Lynwood	Hoffman	12-	28	1988	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	Aug. 25, 1921	67 YRS.			12- 28 1988	12:00 noon M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Frederick County, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frederick	Frederick Memorial Hospital	Custodian US	Postal Servic

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Frederick	YES X NO ☐	497 East Church Street 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frank	Clifford	Hoffman	Stella	Virginia	Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes (IF YES, GIVE WAR OR DATES) 1942-1945	212-14-7236	Michael E. Markle	1731 Dogwood Drive, Frederick, Md. 21701

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above; held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-29-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	12-30-1988	Smithsburg Crematory	Smithsburg, Washington, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701	DEC 30 1988	Julia Davidson-Randall

DHMH - 17 (VR A15 ME (5))

020936 JAN 30 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38139
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: STELLA	MIDDLE: LEEORA	LAST: MORNINGSTAR	2a. DATE OF DEATH MONTH DAY YEAR: 12 27 88	2b. HOUR: 9A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 9 6 03	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD.		
10. CITY OR TOWN OF DEATH: FREDERICK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SEAMSTRESS	12b. KIND OF BUSINESS OR INDUSTRY: CLOTHING		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	FREDERICK	THURMONT	YES ☐ NO ☒	7906 Rocky Acre Drive 21788

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILLIAM	HARLAN	GREEN	NETTIE	O.	HOOVER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	215-05-7247A	William Morningstar	Thurmont, MD 7906 Rocky Acre Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PULMONARY EDEMA	2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY ARTERY DISEASE	YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): AORTIC STENOSIS MITRAL REGURG GI BLEED

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-14, 19 88, to 12-27, 19 88, that (I) (we) last saw the deceased alive on 12-26, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
S Kahn	MD	☐ / ☒ / ☐	12-27-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
S KAHN	4 W 7th ST

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/30/88	GRACEHAM MORAVIAN CEM.	GRACEHAM / FREDERICK / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER, 1621 Opossumtown Pike, Frederick, MD 21701	DEC 28 1988	Julia Davidson-Randall

DHMH - 1650M 1/81 (VRA 15, 4)

020940 JAN 20 88

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 3 8 1 9 0
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	First: Walter	Middle: Eugene	Last: Offutt	2a. DATE OF DEATH Month/Day/Year: 12/22/88	2b. HOUR: 1840 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month, Day, Year: Nov. 4, 1943	6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County, MD.		
10. CITY OR TOWN OF DEATH: Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Receiving Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Magazine Publication		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Frederick	YES [X] NO [ ]	5337 Gold Mine Rd., 21701

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
First: Linwood Middle: T. Last: Offutt, Sr.	First: Helen Middle: Walter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1964-1970	219-44-2850	Mrs. Jean Virts Offutt,	5337 Gold Mine Road Frederick, Md. 21701

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Extensive melanoma	
DUE TO, OR AS A CONSEQUENCE OF (b)	widely metastatic	6 mo
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/9/88, 19__, to 12/22, 19 88, that (I) (we) last saw the deceased alive on 12/22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
		12/22/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. P. Gregory Rausch, M.D.	4 West Seventh St., Frederick, Md. 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 27, 1988	Mt. Olivet Cemetery	Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME (ADDRESS)	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Richard E. Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	DEC 27 1988	Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

020943 JAN 30 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38191
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

1. DECEASED NAME (TYPE OR PRINT)	FIRST: EDWARD	MIDDLE: JOHN	LAST: PAGE	2a. DATE OF DEATH: MONTH December DAY 25, YEAR 1988	2b. HOUR 3:51 a.m.
3. SEX: Male	4. RACE: Cacasion	5. DATE OF BIRTH: MONTH Aug. DAY 8, YEAR 1921	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick County MD.		
10. CITY OR TOWN OF DEATH: Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY: Farm Equip.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Frederick	13c. CITY OR TOWN: Frederick	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 4106 New Design Road/ 21701	
14. FATHER'S NAME: FIRST Joseph MIDDLE William LAST Page		15. MOTHER'S MAIDEN NAME: FIRST Nellie MIDDLE LAST Coughlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 220-03-5082	17. INFORMANT: Mrs. Susanne Blank,	ADDRESS: P.O. Box 31 Buckeystown, Md. 21717	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): BLEEDING PEPTIC AND GASTRIC ULCER, MASSIVE

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): RESPIRATORY INSUFFICIENCY, METASTATIC LUNG CANCER

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 7 19 88 to 12-25 19 88, that (I) (we) last saw the deceased alive on 12-24 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Arthur G. Mansfield — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ARTHUR G. MANSFIELD, M.D.

22e. ADDRESS: 187 Thomas Johnson Dr. Frederick, Md. 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Dec. 28, 1988	23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery	23d. LOCATION: CITY OR TOWN Frederick, COUNTY Frederick, STATE MD	
24. FUNERAL DIRECTOR NAME: Keeney & Basford P.A. Funeral Home	ADDRESS: 106 East Church Street, Frederick, Md. 21701	25a. DATE REC'D. BY REGISTRAR: DEC 27 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 16

DHMH - 16 50M 1/81 (VRA 15, 4)

022255 FEB - 0 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38192 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: EMMA ELIZABETH RHODERICK				2a. DATE OF DEATH MONTH DAY YEAR: December 28, 1988	2b. HOUR: 8:05 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: August 27, 1913	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Frederick, MD.		
10. CITY OR TOWN OF DEATH: Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Waitress	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Frederick	13c. CITY OR TOWN: Walkersville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 96 Sherwood Drive/ 21793	
14. FATHER'S NAME FIRST / MIDDLE / LAST: Unknown / Smith			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Unknown / Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	16b. (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-10-5663	17. INFORMANT: W. Kennard Rhoderick	ADDRESS: 96 Sherwood Dr. Walkersville, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	extensive carcinoma of	
DUE TO, OR AS A CONSEQUENCE OF (b)	with pulmonary mets	2y-3
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/26/88, 19__, to 12/28/88, 19__, that (I) (we) last saw the deceased alive on 12/26/88, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/29/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): P. Gregory Rausch, M.D.	22e. ADDRESS: 4 W. 7th St., Frederick, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/31/88	23c. NAME OF CEMETERY OR CREMATORY: Resthaven Mem. Grdns.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR: Robert E. Dailey & Son, P.A.	ADDRESS: 1201 N. Market Frederick, Md.	25a. DATE REC'D. BY REGISTRAR: JAN 03 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

022256 FEB 9 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

88 38193
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: VIOLA	MIDDLE: M.	LAST: SENGSTACK	2a. DATE OF DEATH MONTH DAY YEAR: 29 DEC 1988	2b. HOUR: 1045 AM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 3 1903	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD.		
10. CITY OR TOWN OF DEATH: FREDERICK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOMEWOOD RETIREMENT CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: FREDERICK	13c. CITY OR TOWN: FREDERICK	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 5736 JEFFERSON BLVD., 21701	
14. FATHER'S NAME FIRST: WILLIAM	MIDDLE	LAST: DIPPLE	15. MOTHER'S MAIDEN NAME FIRST: NETTIE	MIDDLE	LAST: BRENGLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 577-24-6488	17. INFORMANT: Agnes Jeffrey	ADDRESS: 5736 Jefferson Blvd. Frederick, MD 21701	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CHF versus pneumonia	3 weeks
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD & chronic ventricular tachycardia	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)	alzheimers disease	3 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Recurrent urinary tract infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 87 to 29 Dec 88, that (I) (we) last saw the deceased alive on 29 Dec 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James E. Stoner Jr	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/30/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JAMES E. STONER, JR	22e. ADDRESS: 228 N. MARKET ST. FREDERICK, MD. 21701		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 1/3/89	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN: Suitland	COUNTY: PG STATE: MD
24. FUNERAL DIRECTOR NAME: G. DOUGLAS STAUFFER ADDRESS: 1621 Opossumtown Pike, Frederick, MD 21701	25a. DATE REC'D. BY REGISTRAR: JAN 03 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it with page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

020942 JAN 30 89 by FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38194

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Louis — MIDDLE: V. — LAST: Sickenberger Sr.

2a. DATE OF DEATH — MONTH: 12 — DAY: 26 — YEAR: 88

2b. HOUR: 1906 PM M

3. SEX: M

4. RACE: WHITE

5. DATE OF BIRTH — MONTH: JAN. — DAY: 9 — YEAR: 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: FREDERICK MD.

10. CITY OR TOWN OF DEATH: FREDERICK

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FREDERICK MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALESMAN

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: PA — 13b. COUNTY: WESTMORELAND — 13c. CITY OR TOWN: GREENSBURG — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 515 REAMER ST. 77999

14. FATHER'S NAME — FIRST: BLAIR — MIDDLE: — LAST: SICKENBERGER

15. MOTHER'S MAIDEN NAME — FIRST: LENA — MIDDLE: — LAST: HANKINSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 176-05-8806

17. INFORMANT — ADDRESS: Louis V. Sickenberger Yellow Springs, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): COPD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): CVA

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Allen T. Gilson MD — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allen T. Gilson

22e. ADDRESS: 1475 Taney Ave Frederick MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 12/29/88 — 23c. NAME OF CEMETERY OR CREMATORY: GREENSBURG CATHOLIC — 23d. LOCATION CITY OR TOWN: HEMPFIELD — COUNTY: WESTMORELAND — PA 21201

24. FUNERAL DIRECTOR NAME: G. DOUGLAS STAUFFER — ADDRESS: 1621 Opossumtown Pike, Frederick, MD 21701

25a. DATE REC'D. BY REGISTRAR: DEC 27 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

999999

D20947 JAN 30 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 3 3 8 1 9 5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST Lorene	MIDDLE Bell	LAST THOMPSON	2a. DATE OF DEATH MONTH December	DAY 20,	YEAR 1988	2b. HOUR 7:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH April	DAY 29,	YEAR 1920	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.			
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS 58 East South Street, 21701		
14. FATHER'S NAME FIRST Thomas	MIDDLE	LAST Goodman	15. MOTHER'S MAIDEN NAME FIRST Cora	MIDDLE Mae	LAST Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES) None	16b. SOCIAL SECURITY NO. 217-10-0107	17. INFORMANT John Wm. Thompson,	ADDRESS 56 E. South Street Frederick, Md. 21701		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	10m
DUE TO, OR AS A CONSEQUENCE OF (b)	ASHD	5yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Diabetes	10yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/8/88, 19 63, to 12/88, 19 88, that (I) (we) last saw the deceased alive on 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] 22c. DATE SIGNED 12/21/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Timothy Hickey, Jr., M.D.

22e. ADDRESS Parkview Medical Center, Frederick, Md. 217

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec 24, 1988	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN Frederick,	COUNTY Frederick, Md. STATE
24. FUNERAL DIRECTOR NAME Keeney and Basford Funeral Home	ADDRESS 106 East Church Street, Frederick, Md.	25a. DATE REC'D. BY REGISTRAR 21 DEC 22 1988	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

020949 JAN 30 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

38196 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	FREDERICK Gilmore TYERYAR	2a. DATE OF DEATH MONTH DAY YEAR	December 21 1988	2b. HOUR	0410 AM
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	Jan. 8, 1924
6. AGE (IN YEARS LAST BIRTHDAY)	64 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Frederick County MD.				
10. CITY OR TOWN OF DEATH	Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Technician
12b. KIND OF BUSINESS OR INDUSTRY	Bd. of Ed.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Frederick	YES [ ] NO [X]	5731-B Butterfly Lane 21701

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Howard W. Tyeryar	Mary Elizabeth Yeager

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	1942-1946	217-16-2222	Mrs. Lousia B. Tyeryar 5731-B Butterfly Lane, Frederick, Md. 21701

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) TERMINAL METASTATIC LARYNGEAL CARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
[ ]		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 9-18 19 88, to 12-20 19 88, that (I) (we) last saw the deceased alive on 12-20 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Arthur G. Morris M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/21/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Arthur G. Morris M.D.	187 Thomas Johnson Dr. Frederick MD 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-23 1988	Resthaven Mem. Gardens	Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Keeney & Basford Funeral Home 106 East Church St., Frederick, Md. 21701	DEC 22 1988	Julia Davidson-Randall

DHMH - 16 50M 1/81 (VRA 15, 4)

020944 JAN 30 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38197

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be omitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Miriam Lillian Zigler			7a. DATE OF DEATH MONTH / DAY / YEAR	12 24 88
				7b. HOUR	0710 AM
3. SEX	Female	4. RACE	Caucasian	5. DATE OF BIRTH MONTH / DAY / YEAR	Jan. 19, 1914
6. AGE (IN YEARS LAST BIRTHDAY)	74 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Frederick County, MD.				
10. CITY OR TOWN OF DEATH	Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	None				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Maryland	Frederick	Frederick		7068 Basswood Road/21701

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Jacob H. Miller	Annie Derr

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		162-09-9573	Mr. Harold C. Zigler	10544 Stull Road Frederick, Md. 21701

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	pneumonia	
DUE TO, OR AS A CONSEQUENCE OF (b)	pre-terminal bowel	6 hr
DUE TO, OR AS A CONSEQUENCE OF (c)	malignant carcinoid	2 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1987, 19__, to 12/24, 19 88, that (I) (we) last saw the deceased alive on 12/23, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/24/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
P. Gregory Rausch, M.D.	4 West 7th Street Frederick, Md. 21701

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-28-1988	Edge Hill Cemetery	Charles Town, Jefferson, W.Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R.E. DAILEY & SON, P.A.	1201 N. Market St. Frederick, Md. 21701	DEC 27 1988	Julia Davidson-Randall

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

018681 JAN 089

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

S 3 3 1 9 3

REG...

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Everett	DeLouis	Butler	December 30, 1988	1:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	July 7, 1915	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Garrett County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Grantsville	Route 1, Box 96	Brick Tender	Masonry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Garrett	Grantsville	YES ☐ NO ☒	Route 1, Box 96 21536

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Edward	G.	Butler	Mary		Wilt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	187-01-8590	Virginia Butler	Route 1, Box 96 Grantsville, MD 21536

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac failure	1 week
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerosis	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rheumatoid ~~abcess~~ arthritis, peptic ulcer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] Bryce MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	3 Jan 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
George BREZA	912 Seton, Cumberland, Md 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1/2/1989	Frostburg Mem. Park	Frostburg, Allegany, MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[signature]	Grantsville, MD	JAN 03 1989	Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

020148 JAN 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38199

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Ida	MIDDLE: Florence	LAST: HARSH	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ]	MONTH: 12	DAY: 17	YEAR: 19 88	2b. HOUR: 8:18 a M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: MONTH Sept DAY 22 YEAR 1904	6. AGE (IN YEARS, LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 17 YEAR 19 88		2d. HOUR: 8:18 a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Garrett MD					
10. CITY OR TOWN OF DEATH: Oakland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Garrett Co. Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: W. Va.	13b. COUNTY: Preston	13c. CITY OR TOWN: Eglon	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: B ox 95	26716			
14. FATHER'S NAME: FIRST Daniel MIDDLE Grant LAST Judy	15. MOTHER'S MAIDEN NAME: FIRST Rachel MIDDLE LAST Wimer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 232-10-3658B	17. INFORMANT ADDRESS: Artenis B. Harsh - same as 13						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	12-24 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Peritonitis	12-24 hours
DUE TO, OR AS A CONSEQUENCE OF (c)	Pan-metritis with perforation of the uterus	Unknown

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection [X], Inquiry XX, and in my opinion death resulted from: Natural causes XX, Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Herbert H. Leighton M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 18 Dec 1988

EXAMINER'S NAME (TYPE OR PRINT) Herbert H. Leighton, MD ADDRESS Oak @ 5th Sts., Oakland, MD 21550

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/19/88	23c. NAME OF CEMETERY OR CREMATORY Eglon Cemetery	23d. LOCATION CITY OR TOWN Eglon	COUNTY Preston	STATE Md.
24. FUNERAL DIRECTOR NAME Robert H. Durst ADDRESS Durst Funeral Home - Oakland, Md. 21550		25a. DATE RECD. BY REGISTRAR DEC 20 '88	25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton		

DHMH - 17 (VR A15 ME (5))

020079 JAN 23 89

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88 3 8 2 0 0 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] MONTH DAY YEAR	2b. HOUR
THOMAS	ALLEN	LOWER	12-29-88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	Dec. 14, 1953	35 YRS.			12-29-88	1:35a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Garrett County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett County Memorial Hospital	Coal Miner	Coal Mining

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
WV	Grant	Gormania	YES [ ] NO [X]	P.O. Box 26720

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	Wade	Lower	Beatrice	Marie	Pifer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		220-58-0830	Carolyn G. Lower, P.O. Box 7, Bayard, WV

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	1:00AM 12-29-88	driver of an auto/pick-up truck collision

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET OR R.F.D. NUMBER CITY OR TOWN COUNTY STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [X]	hgwy.	Junction of Jasper Riley Road & Rt. 219 Oakland, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] Acting Deputy Chief M.D. MEDICAL EXAMINER DATE SIGNED 12-29-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1/1/1989	Fairview Cemetery	Oakland, Garrett, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradley A. Stewart	Oakland, Maryland 21550	JAN 3 '89	Gloria Davidson-Randall

10/24 2AM BP DRMH - 12 (VR AIS ME (3))

020157 JAN 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38201
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Anna	Elizabeth	HAWKINS	December 28, 1988	7:12P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Feb. 22, 1896	92 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Garrett MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett County Memorial Hospital	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Garrett	Friendsville	YES ☐ NO ☒	Box 42 21531

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	L.	Niner	Mary	Elizabeth	Crates

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS
No	220-28-7602	Mrs. Lorena O'Leary - Kitzmiller, Md. 21538 P.O. Box 410

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Bladder Carcinoma

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark Domenick MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	12/28/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Mark Domenick, M.D.	251 N. 4th St. Oakland, Md. 21550

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/31/88	Paradise Cemetery	Deer Park Garrett Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Durst Funeral Home - Oakland, Md. 21550	DEC 30 '88	Julia Davidson-Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

19720 JAN 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 33202

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Joe	-----	FAULKNER	December 19, 1988	740 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	Aug. 15, 1905	83 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Kentucky	USA		Garrett MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett County Memorial Hospital	Supervisor	B & O Railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Garrett	Deer Park	YES ☐ NO ☒	Route #4, Box 71 21550

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	Washington	Faulkner	Lula	-----	Tyler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		217-16-7902	C. Suzanne Faulkner, See #13 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Right pneumonia — Days

DUE TO, OR AS A CONSEQUENCE OF

(c) metastatic prostate cancer — Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Small bowel obstruction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/4, 19 87, to 12/19, 19 88, that (I) (we) last saw the deceased alive on 12/19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Donald R. Richter	MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-19-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Donald Richter, MD	311 N. Fourth St., Oakland, MD 21550

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	12/21/88	Garrett Co. Mem. Gard	Oakland, Garrett, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradley A. Stewart Oakland, Maryland 21550	DEC 23 '88	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

020724 JAN 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38203
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
WILLIAM	EMORY	ROBINSON	10	28	88	10:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
MALE	WHITE	10	11	10	78 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		Harford Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
MD.	2016 MOUNTAIN RD.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS
MD.	Has	JOPPA		2016 MOUNTAIN RD. 21085

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
SCOTT		ROBINSON			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		215-03-8009	David Robinson-2016 Mountain Rd. Joppa, Md. 21085

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Pulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	dehydration	
DUE TO, OR AS A CONSEQUENCE OF (c)	dementia	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 10/14, 19 88, to 10/[illegible], 19 88, that (I) (we) last saw the deceased alive on 11/[illegible], 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID W. McCLURE M.D.	1131 Beltair Road Bel Air Md 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Removal	10-28-88				

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
State Anatomy Board	Balto., Md.	JAN 23 89	Jackie Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81
(VRA 15, 4)

Items 13a, 13b, 13c, 13e 3-31-89 Film G649

020055 JAN 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - STATE REGISTRAR

REG. NO. 38204

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
LUCY	F.	BROWN	12	21	1988	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
F	WHITE	JAN. 1 1915	73 YRS.			12-21 1988	2:10 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
MAINE	U.S.A.		Howard County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
COLUMBIA	5068 BUCKETPOST CT.	HOMEMAKER	DOMESTIC				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Florida	Sarasota	Venice	YES ☒ NO ☐	695 Posadas Ave 34292

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CROSBY	F.	FRENCH	EDNA	ELIZABETH	CARTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	043-40-5176	FREEMAN F. BROWN, MD.	5068 BUCKETPOST CT COLUMBIA, MD 21045

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Thomas F Herbert M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-21-88

EXAMINER'S NAME (TYPE OR PRINT) Thomas F Herbert MD ADDRESS Ellicott City MD 21043

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	22 DEC 88	BALTIMORE-WASHINGTON CREM. INC.	LAUREL P.G. MD.

24. FUNERAL DIRECTOR NAME: SLACK FUNERAL HOME ADDRESS: BOX 268 ELLICOTT CITY, MD 21043

25a. DATE REC'D. BY REGISTRAR DEC 29 '88

25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 12

DHMH 8017
(VR A15 ME (5))
20M 4/82

020080 JAN 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38205
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Joseph	MIDDLE: —	LAST: Mammarella	2a. DATE OF DEATH MONTH DAY YEAR: 12-30-88	2b. HOUR: 2:30 PM	
3. SEX: M	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 10 10 98	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County	MD.	
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Loreln Nsg & Rehab Ctr	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Tailor	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Howard	Ellicott City	YES ☐ NO ☐	2912 NORMANDY DR. 21043

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
unknown	unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	W.W. II	213-05-8463	Anthony Mammarella	2912 Normandy Drive Ellicott City

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Renal failure	chronic
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic Prostate Carcinoma	months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Atherosclerotic Cardiovascular disease.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from April 88 to Dec 30 88 that (I) (we) last saw the deceased alive on Dec 28 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	12-31-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jerry Levine, MD	11055 Little Patuxent Pkwy, Columbia 21044

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	1-4-89	LORRAINE PARK	WOODLAWN MD.

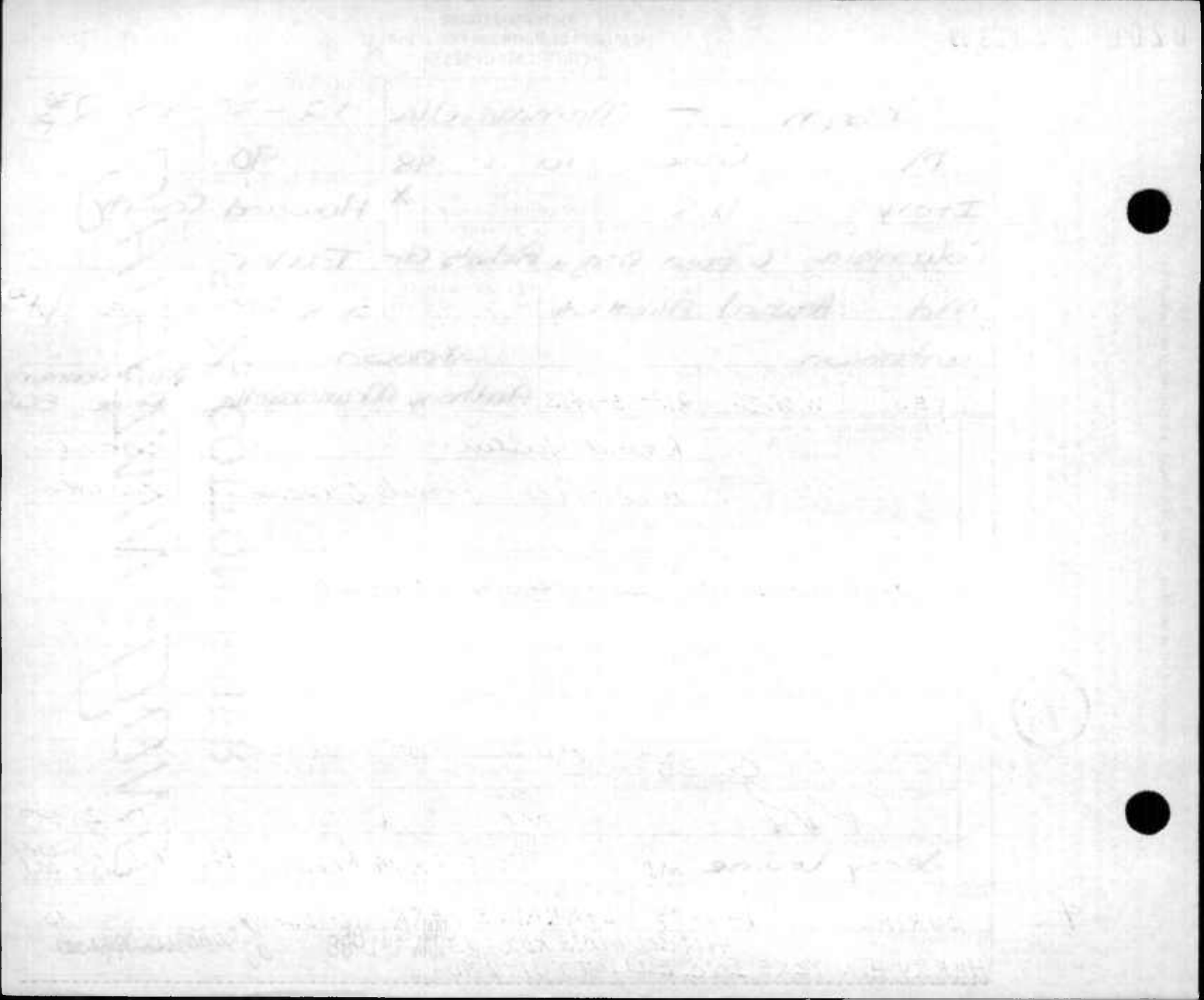
24. FUNERAL DIRECTOR NAME / ADDRESS: HARRY H. WITZKE INC. 412 COLUMBIA RD 21043 ELLICOTT CITY MD.

JAN 01 1988

LOCAL REGISTRAR SIGNATURE

BP 4

DHMH - 16 60M 7/84
(VRA 15, 4)



020198 JAN 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38206

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE (WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Jerry	MIDDLE: J.	LAST: Novotny	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH: 12 DAY: 26 YEAR: 19 88		2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH 11 DAY 2 YEAR 27	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 26 YEAR 19 88	2d. HOUR: 2:53 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Connecticut	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County MD			
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard Co. General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Social Security				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Ellicott City	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 10326 Globe Drive 21043			
14. FATHER'S NAME: FIRST Jerry J. Novotny MIDDLE LAST		15. MOTHER'S MAIDEN NAME: FIRST Bertha MIDDLE Strnad LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): W.W. II	16b. SOCIAL SECURITY NO.	17. INFORMANT: Anne Novotny ADDRESS: 10326 Globe Drive Ellicott City, Md. 21043					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which gove rise to immediate cause (a) stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above held on Autopsy [X] Inspection [ ], Inquiry [ ], and in my opinion death resulted from Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-27-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 12/27/88	23c. NAME OF CEMETERY OR CREMATORY: Westview	23d. LOCATION CITY OR TOWN: Catonsville COUNTY: Baltimore STATE: Md.	
24. FUNERAL DIRECTOR NAME: HARRY H. WITZKE ADDRESS: 4112 Columbia Road Ellicott City, Maryland	25a. DATE REC'D. BY REGISTRAR: DEC 28 '88	25b. REGISTRAR'S SIGNATURE: [signature]		

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

018691 JAN 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33 33207

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the proper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ETHEL	MIDDLE: B	LAST: PORTER	2a. DATE OF DEATH MONTH: 12 DAY: 31 YEAR: 88	2b. HOUR: 20³¹ P.M.	
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 02 DAY: 06 YEAR: 05	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD COUNTY MD.		
10. CITY OR TOWN OF DEATH: Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD CO GENERAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Ellicott City	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 9891 Baltimore Nat'l Pk. 21043	
14. FATHER'S NAME FIRST: Harry	MIDDLE: C.	LAST: Bloom	15. MOTHER'S MAIDEN NAME FIRST: Maude	MIDDLE: G.	LAST: Eckck
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 212-20-8841	17. INFORMANT: GRACE GRAHAM	ADDRESS: 9891 Baltimore Nat'l. Pk. Ellicott City, MD. 21043	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Organic Heart Disease — years

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Artery Disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul D. [illegible]	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 12/31/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 4 Jan 89	23c. NAME OF CEMETERY OR CREMATORY: Poplar Springs Cem.	23d. LOCATION CITY OR TOWN: POPLAR SPRINGS COUNTY: Howard STATE: MD	
24. FUNERAL DIRECTOR NAME: SLACK F.H.	ADDRESS: Po Box 268 Ell. 21043	25a. DATE REC'D. BY REGISTRAR: JAN 5 1989	25b. REGISTRAR'S SIGNATURE: [illegible]	

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

20924 JAN 27 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33209
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Richard Hillen Cromwell Jr.			2a. DATE OF DEATH MONTH DAY YEAR	December 1, 1988
				2b. HOUR	2:50p M
3. SEX	Male	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	April 20, 1928
6. AGE (IN YEARS LAST BIRTHDAY)	60 Yrs YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Baltimore Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Kent County MD.				
10. CITY OR TOWN OF DEATH	Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Kent and Queen Anne's Hosp. Inc.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Executive Steamship Company
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Queen Anne	13c. CITY OR TOWN	Chestertown
13d. INSIDE CITY LIMITS? YES [ ] NO [X]		13e. STREET ADDRESS	RFD # 4 Box # 178		21620
14. FATHER'S NAME FIRST / MIDDLE / LAST	Richard Hillen Cromwell (Sr)			15. MOTHER'S MAIDEN NAME MIDDLE / LAST	Mary Whitely
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	Korean Conflict	16b. SOCIAL SECURITY NO.	006 22 9526
17. INFORMANT	Mary Lou Cromwell	ADDRESS	Rte # 4 Box # 178 Chestertown, Md. 21620		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	respiratory failure	
DUE TO, OR AS A CONSEQUENCE OF (b)	chronic obstructive pulmonary disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	12/2/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bienefeld MD		22e. ADDRESS Chestertown, Md. 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Cremation	Dec 3 1988	Security Process	Catonsville, Md.	
24. FUNERAL DIRECTOR NAME	J. Willis Wells	ADDRESS	J. Willis Wells Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR DEC 02 '88
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall			

BP 26

DHMH - 1650M 1/81 (VRA 15, 4)

Items 18a, 21a, b, c, d, e, f, 22a per med film G649 3/13/89cg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

021245 JAN 31 89

FOR 1 - STATE REGISTRAR

REG. NO. 38209

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HRS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH	DAY	YEAR	2b. HOUR
Demetrius		Fisher	12-	28	1988	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	Black	Aug. 3, 1959	29 YRS.			12-28 1988	5:00 p.m
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH				
Delaware	U.S.A		Kent County, MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Norton	Rt. 1 Box 38	Labor					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Kent	Worton	YES [ ] NO [X]	R.F.D. #1

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Donald		Fisher Sr.	Willow	Mae	Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1977-	221-52-5431	Mr. Donald Fisher	Wm. Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound to the head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	12/28 1988	self-inflicted

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	Rt. Bx. 38 Norton, Kent Co. Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural Causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-29-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1-5-1989	Mt. Olive Cem.	R.F.D. Worton Kent Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Kenneth Wall	Chester Rowland	JAN 10 '89	Julia Davidson-Randall

07/B4 25M BP

DHMH - 17 (VR A15 ME (5))

018755 JAN 11 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33210
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: GERTRUDE MIDDLE: LAST: Waddell WADDELL		2a. DATE OF DEATH MONTH DAY YEAR: December 29 1988	2b. HOUR: 2:10 A M
3. SEX: Female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: December 29 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Kent Co MD
10. CITY OR TOWN OF DEATH: Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Magnolia Hall Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Kent	Chestertown	YES ☒ NO ☐	Washington Ave. 21620

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
J.Thomas Hadaway	Gertrude Carter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		213 03 4747	William H. Waddell	Wilmington, Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca of Pancreas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/1/88 to 12/25/88, that (I) (we) last saw the deceased alive on 12/24/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C. Gottfried Baumann	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. Gottfried Baumann	Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12/31/88	Chester Cemetery	Chestertown, Md. 21620

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. Willis Wells	J. Willis Wells Chestertown, Md.	DEC 29 '88	Gisha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 5+2

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR — SEP 15 '88

REG. NO. 88 38211

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Constance	Monique	Barnes	May 5, 1988	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Black	May 5, 1988	DOA YRS.		DOA 20 min

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Shady Grove Adventist Hospital		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Mont.	Gaithersburg	YES ☐ NO ☒	10002 Forestview Pl. 20879

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Andre	Jon	Smith	Erica	Monique	Barnes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		N/A	mother

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) EXTREME PREMATURITY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
[signature]	M.D.	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☒	5/6/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SITHANANDAM SADHASIVAM M.D	9901 MEDICAL CENTER DR ROCKVILLE MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	N/A	N/A	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rumphrey F.H.	300 W. Montgomery Ave. Rockville, Md.	MAY 11 1988	Julia Davidson-Landers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15. 4)

0198488 JAN 2000

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 338212 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Linda	Carol	Barnes	December 28, 1988	9:30A M

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Female	Caucasian	December 16, 1942	46 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	United States	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Germantown	13520 Wisteria Drive	Secretary	Space Communications

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Germantown	YES ☐ NO ☒	13520 Wisteria Drive / 20874

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Roy	P.	Garnand	Audrey		McCrea

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-	220-40-4940	Vernon L. Barnes, Husband, Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Massive Pulmonary Embolus	Immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Peripheral Thrombophlebitis	One Month
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

High grade glioblastoma of brain

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from October 6, 1988 to December 28, 1988, that (I) (we) last saw the deceased alive on December 16, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Dec.29,1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
G. Peter Pushkas, M.D.	11510 Old Georgetown Road Rockville, Maryland 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	December 31,1988	Ft. Lincoln Cemetery	Brentwood / Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland	DEC 30 '88	Julia Davidson-Randall

022259 FEB 9-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3821 3 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE VMI LAST Billek
2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 12 DAY 30 YEAR 1988
2b. HOUR 0608 M
3. SEX M
4. RACE W1
5. DATE OF BIRTH: MONTH 4 DAY 13 YEAR 33
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 30 YEAR 1988
2d. HOUR 0608
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.
7b. CITIZEN OF WHAT COUNTRY? U.S.A
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD
10. CITY OR TOWN OF DEATH Rockville
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shadygrove Adventist Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED
12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md.
13b. COUNTY Montg.
13c. CITY OR TOWN Poolesville
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS 17300 Hughes Rd.

14. FATHER'S NAME: FIRST ANDREW MIDDLE LAST BILLEK
15. MOTHER'S MAIDEN NAME: FIRST ALICE MIDDLE LAST SCHLENTER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) 1954/57
16b. SOCIAL SECURITY NO. 161-26-2186
17. INFORMANT LEONA BILLEK
ADDRESS 17300 HUGHES RD POOLESVILLE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0500 am 12 30 88
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME
21f. LOCATION STREET 17300 HUGHES RD CITY OR TOWN POOLESVILLE COUNTY MONT STATE MD

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) DEPT MEDICAL EXAMINER
DATE SIGNED 12/31/88
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE ADDRESS 820 WISCONSIN AVE ROCKVILLE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
23b. DATE 1-2-1989
23c. NAME OF CEMETERY OR CREMATORY MONOCACY
23d. LOCATION CITY OR TOWN BEALLSVILLE COUNTY MONTG STATE MD

24. FUNERAL DIRECTOR NAME W.C. HILTON ADDRESS BARNESVILLE, MD.
25a. DATE REC'D BY REGISTRAR JAN 05 1989
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

07/84 25M
BP 85
DHMH - 17 (VR A15 ME (5))

019847 JAN 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 3 3 2 1 4
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Francis	MIDDLE: E.	LAST: Blake	2a. DATE OF DEATH MONTH DAY YEAR: December 31 1988	2b. HOUR: 1:48p M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 20,1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): US Gov't.	12b. KIND OF BUSINESS OR INDUSTRY: Retired	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Mont.	Bethesda	YES [X] NO [ ]	4400 E.W. Highway 20814

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Michael / / Blake	Molly / / Kerns	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578 10 7308	17. INFORMANT / ADDRESS: Elsie Blake (Wife) Same as 13/E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DIABETIC COMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12/30/87-12/31/88
DUE TO, OR AS A CONSEQUENCE OF (b): ANOXEMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): ANEMIA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: —

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES [ ] NO [X]	YES [ ] N/A NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
		N/A

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY
	N/A	Division of the Hospital

22a. I certify that I (this hospital) attended the deceased from 12/30/87 19__ to 12/31/88 19__, that I (we) last saw the deceased alive on 12/31/88 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
W. F. Ferris	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	1/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
W. O Ferris (covering for Dr. Khan)	3701 Rossmoor Blvd Silver Spring MD 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/5/89	Gate of Heaven	S.S. / Mont. / Md.

24. FUNERAL DIRECTOR (NAME AND ADDRESS)	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.	JAN 03 '89	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

020318 JAN 14 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 - 38215 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: DANNY EUGENE BRASHER				2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 25 1988	2b. HOUR: 4:25 P M
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 25 1950	6. AGE (IN YEARS LAST BIRTHDAY): 38 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MISSISSIPPI	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): U.S.NAVY	12b. KIND OF BUSINESS OR INDUSTRY: DEFENSE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MISSISSIPPI	13b. COUNTY: CALHOUN	13c. CITY OR TOWN: CALHOUN CITY	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: RT 3, BOX 83	38916
14. FATHER'S NAME FIRST MIDDLE LAST: LIMMIE DEE BRASHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: ELAINE BOLAND PATTERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): 1968-1988	16b. SOCIAL SECURITY NO.: 587-52-8293	17. INFORMANT ADDRESS: LESLIE J.BRASHER, RT 3, BOX 83,CALHOUN CITY, MI 38916		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): METASTATIC CARCINOMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 8, 1988, to DECEMBER 25, 1988, that (I) (we) last saw the deceased alive on DECEMBER 25, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark S. Georgiadis	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 12/27/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK S. GEORGIADIS, LT, MC, USNR	22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 12-30-1988	23c. NAME OF CEMETERY OR CREMATORY: PITTSBORO CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: PITTSBORO, MISS.	
24. FUNERAL DIRECTOR NAME / ADDRESS: W. W. CHAMBERS CO.INC., SILVER SPRING, Md. 20910			25a. DATE REC'D. BY REGISTRAR: JAN 09'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH-16 50M 1/81 (VRA 15/4)

021060 JAN 3045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR — REG. NO. 3216

1. DECEASED NAME (TYPE OR PRINT): FIRST Millard — MIDDLE - — LAST Brock

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH 12 DAY 26 YEAR 88 — 2b. HOUR M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH Sept. DAY 27, YEAR 1906 — 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 26 YEAR 88 — 2d. HOUR 10:55 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Kensington — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4111 Warner St. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer — 12b. KIND OF BUSINESS OR INDUSTRY: Aeronautical

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Montg. — 13c. CITY OR TOWN: Kensington — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 4111 Warner St. /20857

14. FATHER'S NAME: FIRST George — MIDDLE - — LAST Brock

15. MOTHER'S MAIDEN NAME: FIRST Georgianna — MIDDLE - — LAST Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ---------- — 16b. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Roland E. Brock — ADDRESS: 4533 Via Santa Maria Santa Maria CA. 93455

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? Head Only YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

Head Only

ACTUAL SIGNATURE _____ M.D. — TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED 12-27-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. — ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation — 23b. DATE 1-13-1989 — 23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory — 23d. LOCATION CITY OR TOWN Riverdale — COUNTY P.G. — STATE Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: W.W. Chambers Co. Inc. Riverdale Md. 5801 Cleveland Ave. 20737 — 25a. DATE REC'D BY REGISTRAR JAN 17 89 — 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP 5

DHMH - 17 (VR A15 ME (5))

3

Brooks, James

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 88 3 3 2 1 7

0213883 FEB 1 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

Case Released by Dr John Rogers 12/26/88 1AM
J. Indisano MD 12/26/88 11AM

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES MIDDLE:	LAST: BROOKS	2a. DATE OF DEATH MONTH: 12 DAY: 25 YEAR: 1988	2b. HOUR: 11:45 P M		
3. SEX: Male	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 07 DAY: 11 YEAR: 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self employed	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Washington, D.C.	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: Grant Park Nursing Home 99999	
14. FATHER'S NAME FIRST MIDDLE LAST: James Albert Brooks	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Edith Thomas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579 38 9230	17. INFORMANT ADDRESS: Lisa Ashe-Granddaughter-99 South Cottage			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	MYOCARDIAL INFARCTION	
DUE TO, OR AS A CONSEQUENCE OF (c)	CORONARY ARTERY DISEASE	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/25, 19 88, to 12/25, 19 88, that (I) (we) last saw the deceased alive on 12/25, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Hector K. Collison DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): HECTOR K. COLLISON MD

22e. ADDRESS: 1111 SPRING ST SILVER SPRING MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: December 31, 1988	23c. NAME OF CEMETERY OR CREMATORY: Lees Crematorium	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington, D.C.	
24. FUNERAL DIRECTOR NAME: John S. Stewart, III Stewart Funeral Home	ADDRESS: 4001 Benning Road, N.E.	25a. DATE REC'D. BY REGISTRAR: JAN 30 1989	25b. REGISTRAR'S SIGNATURE: Julia Snyder Randall	

BP 99999

DHMH 16 60M 7/84
(VRA 15, 4)

020166 JAN 23 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M

BP 4

DHMH - 17 (VR A15 ME (5))

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 3 2 1 3

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Ronald	MIDDLE: L.	LAST: Brown	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH: 12 DAY: 29 YEAR: 1988	2b. HOUR: M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 2 DAY: 12 YEAR: 51	6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS.	IF UNDER 1 YR. MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN:	2c. DATE PRONOUNCED DEAD MONTH: 12 DAY: 29 YEAR: 1988	2d. HOUR: 1:06 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD				
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Clarksville	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS: 13565 Highland Road 21029			
14. FATHER'S NAME FIRST: Marion	MIDDLE: L.	LAST: Brown	15. MOTHER'S MAIDEN NAME FIRST: Lena	MIDDLE: S.	LAST: Shoemaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Marion Brown	ADDRESS: 13565 Highland Road Clarksville, Md. 21029			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 12:05 XX 12-29 1988	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): motorcyclist lost control struck fixed objects
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road	21f. LOCATION STREET: 1700 blk. Brink Road, CITY OR TOWN: Montgomery Co., COUNTY: Md. STATE:

22a. I certify that I took charge of the remains described above; held an: Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 12-29-88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 12/30/88	23c. NAME OF CEMETERY OR CREMATORY: Westview	23d. LOCATION CITY OR TOWN: Catonsville Balto. STATE: Md.
24. FUNERAL DIRECTOR NAME: HARRY H. WITZKE	ADDRESS: 4112 Columbia Road Ellicott City, Maryland 21043	25a. DATE REC'D. BY REGISTRAR: DEC 30 '88	25b. REGISTRAR'S SIGNATURE: Lilia Davidson-Randall

019844 JAN 20 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 89 3 3 2 1 9

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Lee	Vangeline	Cary	12/31/88	7:25p M

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Female	Black	11 04 36	52y YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Alabama	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Wheaton	YES ☐ NO ☐	3701 Kenway Street 20906

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Lee	Andrew	Shephard	Rhydonia		Robinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		418-52-2520	John M. Cary	Husband Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/29 19 88 to 12/31 19 88 that (I) (we) last saw the deceased alive on 12/31 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature] MD	MD	☐ / ☒ / ☐	12/31/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Robert Gold	15225 Shady Grove Road Rockville, Md.20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Jan.5,1989	Gate of Heaven	Silver Spring Montgomery Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis J. Collins, Jr.	500 University Blvd.,W. Silver Spring,Md.20901	JAN 04 '89	Julia Davidson-Randall

BP 22

DHMH - 16 50M 1/81 (VRA 15, 4)

019843 JAN 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 33220

1. DECEASED NAME (TYPE OR PRINT): FIRST Ellen MIDDLE L. LAST Caspar
2a. DATE OF DEATH: MONTH 12 DAY 31 YEAR 88
2b. HOUR 10 26 AM
3. SEX: FEMALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH JUNE DAY 7 YEAR 1901
6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, DC
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOLY CROSS HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY
12b. KIND OF BUSINESS OR INDUSTRY: H.O.L.C.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
13b. COUNTY
13c. CITY OR TOWN: WASH, DC
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 4416 ILLINOIS AVE, NW 20011

14. FATHER'S NAME: FIRST FRANCIS MIDDLE P. LAST McCANN
15. MOTHER'S MAIDEN NAME: FIRST MATILDA MIDDLE LAST SCOTT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 577-60-0144
17. INFORMANT: BROTHER ADDRESS: 4740 CONN AVE, NW
LEO P. McCANN #607 WASHINGTON, DC 20008

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASTEMIC MULTIPLE ORGAN FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b): SEPSIS TO OLD PERFORATED ULCER
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION: 12/5/88
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Small L. intestinal abscess
20a. AUTOPSY YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/14, 19 88, to 12/31, 19 88, that (I) (we) last saw the deceased alive on 12/30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/31/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. EICHLER
22e. ADDRESS: 5915 PENROSE DR Chevy Chase MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: JAN 3, 1989
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
23d. LOCATION CITY OR TOWN: WASHINGTON, DC COUNTY STATE

24. FUNERAL DIRECTOR NAME: FRANCIS J. COLLINS, JR.
ADDRESS: 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901
25a. DATE REC'D. BY REGISTRAR: JAN 04 '89
25b. REGISTRAR'S SIGNATURE: Lisha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 50M 5/81 (VRA 15.4)

023323 FEB 21 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38221 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Lorna	Lee	Clay	December 7, 1988	12:18 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	BLACK	December 7, 1988	YRS.		1 / 2

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Rockville			Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Shady Grove Adventist	N/A	N/A

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	3730 Bel-Pre Rd. #8 20906

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Louis	Dean	Clay	Lorna	Elizabeth	Armstrong

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Extremely Inmature

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Miguel A Diaz MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	12-7-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MIGUEL DIAZ MD	SHADY GROVE HOSPITAL 9901 Medical Center Dr. Rockville Md 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	N/A	Shady Grove Hospital	Rockville Mont. Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
N/A	DEC 14 1988	

0 1 9 8 4 2 JAN 2 0 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33222
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): Hilda (FIRST) Mouser (MIDDLE) Crenshaw (LAST)

2a. DATE OF DEATH: 12 (MONTH) 28 (DAY) 88 (YEAR) — 2b. HOUR: 11:35 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Aug. 13, 1888

6. AGE (IN YEARS LAST BIRTHDAY): 100 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bethesda Retirement Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 5301 Westbard Circle 20816

14. FATHER'S NAME: Sands (FIRST) Kenyon (MIDDLE) Gorham (LAST)

15. MOTHER'S MAIDEN NAME: Maude (FIRST) Shethar (MIDDLE)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 541-54-4677

17. INFORMANT: Dr. Sands Irani, 9425 Locust Hill Rd., Beth. Md. 20814 (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Cardio pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immed.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (this hospital) attended the deceased from 3/23 19 88 to 12/28 19 88 that (we) last saw the deceased alive on 12/28 19 88 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (not) view the body after death.

22b. SIGNATURE: J. Blaine Fitzgerald M.D. — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/28/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Blaine Fitzgerald M.D.

22e. ADDRESS: 8218 Wi. Ave., Bethesda, M.D. 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 12-29-88

23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort

23d. LOCATION: CITY OR TOWN — COUNTY — STATE: Alexandria, Virginia

24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons. ADDRESS: 5130 Wi.Ave. N.W., Washington, D.C.

25a. DATE FILED BY REGISTRAR: DEC 30 '88

25b. REGISTRAR'S SIGNATURE: Lisa Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner notified 12/29/88

BP 1/2

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 3 8223

0198 30 JAN 2 '89

1. DECEASED NAME (TYPE OR PRINT): First: John; Middle: Joseph; Last: Woodrow Doonan
2a. DATE OF DEATH: December 29, 1988
2b. HOUR: 9:50 PM
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: Nov. 5, 1912
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. (If under 1 year: Months; Days. If under 24 hrs: Hours; Min.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 15518 Monona Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pilot
12b. KIND OF BUSINESS OR INDUSTRY: Commercial Airlines

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES ☐ NO XX
13e. STREET ADDRESS: 15518 Monona Drive/20855

14. FATHER'S NAME: First: Frank; Middle: ; Last: Doonan
15. MOTHER'S MAIDEN NAME: First: Catherine; Middle: ; Last: Walsh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 197-01-7250
17. INFORMANT ADDRESS: Elizabeth G. Doonan, Wife, Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac standstill — Approximate interval between onset and death: immediate
DUE TO, OR AS A CONSEQUENCE OF (b): coronary artery disease — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): arteriosclerosis, generalized — 25 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): multinfarct dimentia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO XX
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept. 30, 19 76, to Dec. 29, 19 88, that (I) (we) last saw the deceased alive on Dec. 10, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: John Collin Harvey M.D. — DEGREE: ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: Dec. 30, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John C. Harvey, M.D.
22e. ADDRESS: 3800 Reservoir Rd., N.W., #2201, Washington, DC 20007

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Jan. 2, 1989
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION CITY OR TOWN; COUNTY; STATE: Rockville, Maryland
24. FUNERAL DIRECTOR (NAME AND ADDRESS): Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850
25a. DATE REC'D. BY REGISTRAR: JAN 03 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 75+9

DHMH - 10 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

018270 JAN 6 89

1 - FOR STATE REGISTRAR

REG. NO. 88 38224

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Vasiliki; MIDDLE: N.; LAST: Drogaris DROGARIS
2a. DATE OF DEATH — MONTH DAY YEAR: December 31, 1988
2b. HOUR: 1:45 A M
3. SEX: FEMALE
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: Sept. 24, 1910
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Greece
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY County MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Virginia
13b. COUNTY: V
13c. CITY OR TOWN: Hopewell
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 507 Appomattox Street / 23860

14. FATHER'S NAME — FIRST: Antoniou; MIDDLE; LAST: Klonis
15. MOTHER'S MAIDEN NAME — FIRST: Katina; MIDDLE; LAST: (Unavailable)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 226-92-5682
17. INFORMANT — ADDRESS: Paul Fotopoulos, 11213 Hunt Club Drive Potomac, MD 20854

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ant? aortic dissection — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): arter sclerosis — yrs
DUE TO, OR AS A CONSEQUENCE OF (c): with shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ASHD / CHF by HX

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (hospital) attended the deceased from 12-30, 19 88, to 12-31, 19 88, that (I) (last) saw the deceased alive on 12-31, 19 88, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.
22b. SIGNATURE: John S Said — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/31/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. S. SAID MD
22e. ADDRESS: 809 Viers Mill Rd Rockville

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 1-3-89
23c. NAME OF CEMETERY OR CREMATORY: Appomattox Cemetery
23d. LOCATION CITY OR TOWN: Hopewell, COUNTY: Virginia STATE:
24. FUNERAL DIRECTOR NAME: Gould Funeral Home ADDRESS: 214 North 6th Avenue, Hopewell, VA 23860
25a. DATE REC'D BY REGISTRAR: JAN 04 1989
25b. REGISTRAR: Gladys Gardner Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes", the medical examiner must be notified of any injury, or other traumatic event, the medical evidence must be studied and the cause of death certified by the medical examiner.

RELEASED BY MEDICAL EXAMINER

BP 4999

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

019840 JAN 20 00

REG. NO 88 33225

1. DECEASED NAME (TYPE OR PRINT) First: Margaret Middle: L. Last: Dunlop

2a. DATE OF DEATH Month: 12 Day: 30 Year: 88

2b. HOUR 7:39 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH Month: Oct. Day: 9 Year: 1913

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 8808 Colesville Rd. 20910

14. FATHER'S NAME First: James Middle: O. Last: Langrall

15. MOTHER'S MAIDEN NAME First: Elizabeth Middle: Last: Courtney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A

16b. (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 215-46-1914

17. INFORMANT (son) ADDRESS: James F. Dunlop, III 9413 Wareham Ct. Vienna, Va. 22180

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiac failure — Approximate interval between onset and death: 4 d.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Prolonged hypotension — 4 d

DUE TO, OR AS A CONSEQUENCE OF (c): Upper Gastrointestinal Hemorrhage — 2 wks.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe hepatic cirrhosis, respiratory failure

19a. DATE OF OPERATION: 12/24/88 12/26/88

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Upper GI bleeding

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 24, 19 88, to Dec 30, 19 88, that (I) (we) last saw the deceased alive on Dec 29, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ernest D. Hanowell — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ERNEST D. HANOWELL

22e. ADDRESS: 10401 OLD GEORGETOWN RD. BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-4-1989

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington, DC

24. FUNERAL DIRECTOR NAME / ADDRESS: Hines/Rinaldi funeral Home 11800 N.H. Ave., Silver Spr. Md.

25a. DATE REC'D BY REGISTRAR: JAN 03'89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R BP 16

DHMH - 1650M 1/81 (VRA 15, 4)

008655 SEP 29 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38226

1. DECEASED NAME (TYPE OR PRINT): ROBERT SCOBIE FAIRWEATHER

2a. DATE OF DEATH: SEPTEMBER 17 1988

2b. HOUR: 9:35 PM

3. SEX: MALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: NOVEMBER 17 1910

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW JERSEY

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY: U.S.M.C.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: VIRGINIA

13b. COUNTY:

13c. CITY OR TOWN: ALEXANDRIA

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 8 COCKRELL AVENUE 22304

14. FATHER'S NAME: WILLIAM O. FAIRWEATHER

15. MOTHER'S MAIDEN NAME: ANNE WATSON SCOBIE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES

(IF YES, GIVE WAR OR DATES): 1929-1954

16b. SOCIAL SECURITY NO.: 579-50-9786

17. INFORMANT ADDRESS: JESSIE D.FAIRWEATHER,8 COCKRELL AVENUE, ALEXANDRIA, VA 22304

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

(b): CHRONIC RENAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Approximate interval between onset and death:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 13 19 88 to SEPTEMBER 17 19 88 that (I) (we) last saw the deceased alive on SEPTEMBER 17 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James A Butler DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 19 Sept 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.A.BUTLER, LT, MC, USN

22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 9/22/88

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION: CITY OR TOWN: Arlington, VA / COUNTY / STATE

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Everly-Wheatley Funeral Home 1500 W. Braddock Road, Alexandria, VA

25a. DATE REC'D. BY REGISTRAR: SEP 26 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 10/SOM 1/81 (VRA 15, 4)

120201 JAN 23 89 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 38227 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT) FIRST: ANNA	MIDDLE	LAST: FREIDE	2a DATE OF DEATH MONTH/DAY/YEAR: 12/27/88	2b HOUR: 12 59 A M
3 SEX: Female	4. RACE: White	5 DATE OF BIRTH MONTH/DAY/YEAR: 12/28/04	6 AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.	
10 CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hebrew Home of Greater Wash.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b KIND OF BUSINESS OR INDUSTRY: at home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS
Virginia	Fairfax	Great Falls	YES ☐ NO ☒	9245 Wood Glade Dr.

14 FATHER'S NAME FIRST / MIDDLE / LAST	15 MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Samuel / Hartz	Fannie / Richmond

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
No			William Feide 9245 Wood Glade Dr. Great Falls, Va.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from 12/20 19 88, to 12/27 19 88, that (I) (we) last saw the deceased alive on 12/27 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
Steven Lipson	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	1/9/89

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
STEVEN LIPSON	6121 MONTROSE RD, ROCKVILLE

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 29, 1989	King David	Falls Church Fairfax Va.

24 FUNERAL DIRECTOR NAME / ADDRESS	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Everly Funeral Home 10565 Main St. Fairfax, VA.	JAN 19 1989	Julia Knudsen Rankin

BP

DHMH - 1650M-1/81 (VRA15.4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38223

019836 JAN 20 89

1. DECEASED NAME (TYPE OR PRINT): First Gerda; Middle Gladys; Last Fuller
2a. DATE OF DEATH: Month Dec. Day 27, Year 1988
2b. HOUR: 4:50A M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Month Oct. Day 7 Year 1923
6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12702 Laurie Drive
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Adm. Asst.
12b. KIND OF BUSINESS OR INDUSTRY: Singer Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 12702 Laurie Drive 20904

14. FATHER'S NAME: First William; Middle; Last Osborne
15. MOTHER'S MAIDEN NAME: First Gerda; Middle Marie; Last Greenj
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): N/A
17. INFORMANT: (son) John E. Fuller, 3rd. ADDRESS: 8007 Park Lane Beth., Md. 20814

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SUDDEN CARDIAC DEATH — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — SEVERAL YRS
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: MALIGNANT LYMPHOMA, LARGE CELL TYPE

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (the ~~attending physician~~) attended the deceased from AUGUST 20, 19 88, to DECEMBER 27 19 88, that ~~I~~ (we) last saw the deceased alive on DECEMBER 27 19 88, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) ~~did~~ (did not) view the body after death.
22b. SIGNATURE: James A. Brown DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/27/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. James Brown
22e. ADDRESS: 4404 Queensbury Road Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12-27-88
23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory
23d. LOCATION: CITY OR TOWN Alexandria; COUNTY; STATE Virginia
24. FUNERAL DIRECTOR: NAME AND ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md
25a. DATE REC'D. BY REGISTRAR: DEC 30 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 3 8 2 2 9

0198 2 7 JAN 20 89

1. DECEASED NAME (TYPE OR PRINT): First: Salem; Middle: Samir; Last: Gafsi

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: 12 Day: 31 Year: 1988

2b. HOUR: M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month Day Year: Feb. 20 1971

6. AGE (IN YEARS LAST BIRTHDAY): 17 YRS.

IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month: 12 Day: 31 Year: 1988

2d. HOUR: 3:25A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Minnesota

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4608 Verne Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student

12b. KIND OF BUSINESS OR INDUSTRY: School

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 5905 Osceola Rd. 20816

14. FATHER'S NAME: First: Salem; Middle: ; Last: Gafsi

15. MOTHER'S MAIDEN NAME: First: Beverly; Middle: ; Last: Boyce

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 471 70 8805

17. INFORMANT ADDRESS: Salem Gafsi-father- (same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple injuries

9238

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 3:25 PM 12 31 1988

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Pipe bomb explosion

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): garage

21f. LOCATION: STREET: 4608 Verne Road; CITY OR TOWN: Bethesda; COUNTY: Mont.; STATE: MD

22a. I certify that I took charge of the remains described above held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER

DATE SIGNED: 1/1/89

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-4-1989

23c. NAME OF CEMETERY OR CREMATORY: George Wash. Cemetery

23d. LOCATION CITY OR TOWN: Adelphi; COUNTY: Pr. Georges; STATE: Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR: JAN 05 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))

021059 JAN 3 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38230
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	TEOFILO / P. / GALDO	2a. DATE OF DEATH MONTH DAY YEAR	12 30 88	2b. HOUR	7:20 AM
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	Feb. 29, 1890
6. AGE (IN YEARS LAST BIRTHDAY)	98 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Peru	7b. CITIZEN OF WHAT COUNTRY?	Peru	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD
10. CITY OR TOWN OF DEATH	Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Circle Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired
12b. KIND OF BUSINESS OR INDUSTRY	Farmer				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	Maryland	13b. COUNTY	Montgomery	13c. CITY OR TOWN	Gaithersburg
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐	13e. STREET ADDRESS	11 Fullview Ct. 20878		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Issac / / Galdo	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Modesta / / Pezo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	----------	16b. SOCIAL SECURITY NO.	None
17. INFORMANT ADDRESS	Santos Galdo (son) same as 13e				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ASPIRATION PNEUMONIA	2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC ORGANIC BRAIN SYNDROME WITH SEVERE DEMENTIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Sept 6, 19 88, to 12/30, 19 88, that (I) (we) last saw the deceased alive on 12/29, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	Martin Shaegel	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	12/30/88		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	MARTIN C SHAEGEL	22e. ADDRESS	3720 FARRAGUT AVE KENSINGTON, MD 20895

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	1/4/89	Gate of Heaven Cemetery	Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME / ADDRESS	Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR	JAN 3'89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

19757 JAN 19 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please mail cards to papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

BP 40

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38231

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: D.	LAST: Gauss	2a. DATE OF DEATH MONTH DAY YEAR: 12/27/88	2b. HOUR: 7:15 P M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: November 11, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	# UNDER 1 YEAR: MONTHS / DAYS	# UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Bethesda	YES [ ] NO [X]	4503 Harling Lane/ 208[illegible]

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
George / Denner	Elizabeth / Purvis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No	179-01-8464	Arthur Gauss same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): chronic obstructive lung disease, bone marrow aplasia 1978

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
[ ]		

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May, 19 88, to Dec 27, 19 88, that (I) (we) last saw the deceased alive on Dec 27, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	22c. DATE SIGNED
[signature] ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	December 28, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William Carina	4912 Adrian St Rockville MD 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	December 28, 1988	Montgomery Crematorium, Inc.	Bethesda/Montgomery/Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814	DEC 30 '88	Julia Davidson-Randall

020946 JAN 30 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38232 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): First Douglas Middle Martin Last GREENE — Douglas M GREENE
2a. DATE OF DEATH: Month 12 Day 20 Year 88
2b. HOUR: 1:30 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month Sept. Day 29, Year 1916
6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cartographer
12b. KIND OF BUSINESS OR INDUSTRY: Maps

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 10317 Brunswick Ave., 20902

14. FATHER'S NAME: First John Middle Lewis Last Greene
15. MOTHER'S MAIDEN NAME: First Carrie Middle May Last Barrick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 1940-1945
16b. SOCIAL SECURITY NO.: 217-10-0193
17. INFORMANT: Mrs. Jeannette Greene ADDRESS: 10317 Brunswick Ave., Silver Spring, Md. 20902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory / Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO, OR AS A CONSEQUENCE OF (b): Intracerebral Hemorrhage — 12 days
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 8, 19 88, to Dec 20, 19 88, that (I) (we) last saw the deceased alive on Dec 19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: Dec. 20, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Richard GELFAND
22e. ADDRESS: 5620 Shields Drive Bethesda, Md 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-23-1988
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION: CITY OR TOWN Frederick, COUNTY Frederick, STATE Md.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Keeney & Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701
25a. DATE REC'D. BY REGISTRAR: DEC 22 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 38233
REG. NO.

019835 JAN 20 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
STARR	S.	GREGORY	DECEMBER 26 1988	6:30 A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
FEMALE	CAUCASIAN	SEPTEMBER 16 1912	76 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED WIDOWED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH		
TEXAS	UNITED STATES		MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL	SECRETARY	HOWARD HUGHES INDUS.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	BETHESDA	YES NO X	6407 KIRBY ROAD 20817

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
NOT AVAILABLE		SANFORD	PEGGY		NATIONS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-	576-32-6236	FRANK GREGORY	6407 KIRBY ROAD, BETHESDA, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC LIVER DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES X NO	YES X NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK NOT WHILE AT WORK					

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 5, 19 88, to DECEMBER 26, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 26, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Mark S. Georgiadis	MD	ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN X	12/27/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARK S. GEORGIADIS, LT, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	DECEMBER 29, 1988	GATE OF HEAVEN CEMETERY	SILVER SPRING,	MARYLAND	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA CHEVY CHASE, INC.	7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814	DEC 30 '88	Julia Davidson-Kendall

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 (and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP ID

DMMH - 16 50M 1/81 (VRA 15, 4)

019762 JAN 19 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 89 38234

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be accurately completed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARION	MIDDLE	LAST: HOLFORD	2a. DATE OF DEATH MONTH DAY YEAR: 12/27/88	2b. HOUR: 5:12 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug 8 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NIH-Adm. Assistant	12b. KIND OF BUSINESS OR INDUSTRY: Retired
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 10101 Grosvenor Place 20852
14. FATHER'S NAME FIRST: Albert	MIDDLE	LAST: Decker	15. MOTHER'S MAIDEN NAME FIRST: Clara	MIDDLE	LAST: Plastil
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 579 10 6818	17. INFORMANT ADDRESS: 12490 W. Nugget Ct. Highland, Md. Michael Clements (Son in Law)		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(a) IMMEDIATE CAUSE: Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Lung injury

DUE TO, OR AS A CONSEQUENCE OF

(c) Injuries suffered when struck by car

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).: Age, Neuropathy

19a. DATE OF OPERATION: 12/24	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Trauma, Liver injury	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12 P.M. 12 24 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): Struck by car	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Street	21f. LOCATION STREET: ? CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/24, 19 88, to 12/27, 19 88, that (I) (we) last saw the deceased alive on 12/27, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A Krantz MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/28

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Alan Bruce Krantz — 22e. ADDRESS: 9800 Kelly Pl #104

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/30/88	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland PG Md	
24. FUNERAL DIRECTOR AND ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR: DEC 30 '88	25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall	

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38235

019834 JAN 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. DECEASED NAME (TYPE OR PRINT) First: EDITH	Middle: Claude	Last: JARVIS	2a. DATE OF DEATH Month: 12 Day: 29 Year: 88	2b. HOUR 817 PM M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH Month: 11 Day: 05 Year: 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Director/Jarvis	12b. KIND OF BUSINESS OR INDUSTRY: School Bureau		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Chevy Chase	YES ☒ NO ☐	9 E. Melrose Street / 20815

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
Herbert / / Claude	Cicely / / Armes	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-	578-01-0458	Mrs. Patricia Floyd Nagel, Cousin, 4508 Fourth Road,N., Arlington, VA. 22203

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ELECTRICAL - MECHANICAL DISSOCIATION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY HEART DISEASE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 12-28, 19 88, to 12-29, 19 88, that (I) (~~we~~) last saw the deceased alive on 12-29, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thomas H. Sinderson, MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-29-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
THOMAS G. SINDERSON	6410 ROCKLEDGE DRIVE BETHESDA, Md 20817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	December 30,1988	Montgomery Crematorium Inc.	Bethesda / Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland	JAN 03'89	Julia Davidson-Randell

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 9 7 6 1 JAN 19 89

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 88 3 8 2 3 6

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Charles — MIDDLE: — LAST: Johnson

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH 12 DAY 28 YEAR 1988 — 2b. HOUR 1250 M

3. SEX: male — 4. RACE: white — 5. DATE OF BIRTH: MONTH 11 DAY 28 YEAR 32 — 6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 28 YEAR 1988 — 2d. HOUR 1250 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Draftsman

12b. KIND OF BUSINESS OR INDUSTRY: L P Gonzer Assoc.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: New York — 13b. COUNTY: Ulster — 13c. CITY OR TOWN: Kingston — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 66 South Manor Avenue 12401

14. FATHER'S NAME: FIRST John — MIDDLE F. — LAST Johnson

15. MOTHER'S MAIDEN NAME: FIRST Viola — MIDDLE MacDonough — LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Korean

16b. SOCIAL SECURITY NO.: 102 24 6880

17. INFORMANT: Sister Marilyn A. Perry — ADDRESS: 974 Farmhaven Drive Rockville, MD 20850

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John Tauber — M.D. — TITLE (SPECIFY): Deputy Medical Examiner — DATE SIGNED: 12-28-88

EXAMINER'S NAME (TYPE OR PRINT): John Tauber — ADDRESS: 8218 Wisconsin Ave. Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 31, 1988

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Kingston, New York

24. FUNERAL DIRECTOR NAME / ADDRESS: Robert A. Pumphrey Funeral Home, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850

25a. DATE REC'D. BY REGISTRAR: DEC 30 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL

DHMH 17 (VR A15 ME (5))

Items21b,f PerM.E. FilmG652 6/9/89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 33237

020937 JAN 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR	2b. HOUR
GAIL	MARIE	KEESEE	12-23-88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	Caucasian	Apr. 2, 1955	33 YRS.			12-23-88	8:40a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	
La.	U.S.A.		Montgomery County	MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Shady Grove Hospital	secretary	~~refrigeration contractor~~	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Fredercik	Middletown	YES ☐ NO ☒	1313 Mt. Church Rd.	21769

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Emmitt		Barrios	Betty	jean	Pintato

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		433-08-7436	Kerry B. Keesee	Middletown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8120

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	8:30 PM 12-23-88	driver of an auto/bus impact

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		COUNTY	STATE
	street	~~124 Rickenbacker Drive nr. Airport Road~~ Rt. 124 N. of Rickenbachen Rd.	Gaithersburg, Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 12-24-88

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	12/28/88	Smithsburg Crematory	Smithsburg	Wash.	Md.

24. FUNERAL DIRECTOR (SIGNATURE AND NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Thompson Funeral Home	Middletown Md. 21769	DEC 28 1988	Julia Davidson-Randall

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

019833 JAN 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 3 8 2 3 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	MONTH	DAY	YEAR	2b. HOUR
	Ernest	Paul	Kelly		12	29	19 88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR
MALE	WHITE	APRIL 26 1919	69 YRS.			12-29- 19 88		11:22 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MICHIGAN	U.S.A.		Montgomery County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	OFFICE MANAGER	U.S. STEEL

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES ☐ NO ☐	15035 EARDLEY COURT 20906

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ALFRED	ERNEST	KELLY	ETHEL	MAE	JENKIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		383-09-6046	VIRGINIA C. KELLY	WIFE SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple injuries	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

8/29

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	11:00PM 12-29-88	Occupant involved in car/truck collision

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	road	Connecticut Avenue & Bel Pre Road, Aspen Hill, Montgomery County, MD

22a. I certify that I took charge of the remains described above; held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-30-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

VC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	DEC. 31, 1988	METROPOLITAN CREMATORY	ALEXANDRIA VIRGINIA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	JAN 04 '89	Julia Davidson-Randell

07/84 MAS BP

DHMH - 17
(VR A15 ME (5))

019763 JAN 19 88 BY STATE REGISTRAR

Item#18a Pt. 2 22a per med Film FOR G649 3/31/89cg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38239

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SHIN HO	MIDDLE:	LAST: KIM	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR: 12 26 19 88	2b. HOUR: M		
3. SEX: Male	4. RACE: Korean	5. DATE OF BIRTH MONTH DAY YEAR: Apr. 6 1935	6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS.	IF UNDER 1 YR. MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 12 26 19 88	2d. HOUR: 8:25 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Korea	7b. CITIZEN OF WHAT COUNTRY?: Permanent Res.-U.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.				
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Merchant	12b. KIND OF BUSINESS OR INDUSTRY: Self-employe				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 13501 Bartlett Street	20853		
14. FATHER'S NAME FIRST: Duknam	MIDDLE:	LAST: Kim	15. MOTHER'S MAIDEN NAME FIRST: Jung	MIDDLE:	LAST: Rye		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-96-9126	17. INFORMANT: Hakang Kim (wife)	ADDRESS: 13501 Bartlett St. Rockville, Md 20853			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pulmonary tuberculosis (remote)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above. Autopsy [X] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ].

ACTUAL SIGNATURE: Charles P. Kokes M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 12-27-88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Dec 28,1988	23c. NAME OF CEMETERY OR CREMATORY: Norbeck Memorial Park	23d. LOCATION CITY OR TOWN: Olney	COUNTY: Montgomery STATE: Maryland
24. FUNERAL DIRECTOR NAME: Hines/Rinaldi F.H.	ADDRESS: 11800 New Hampshire Ave. Silver Spring, Maryland	25a. DATE REC'D. BY REGISTRAR: DEC 30 '88	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

07/84 25M BP DHMH-17 (VR A1S ME (5))

0 1 9 8 3 2 JAN 20 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 3 8 2 4 0

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JOSEPH / J. / KING	2a. DATE OF DEATH MONTH DAY YEAR	DECEMBER 28, 1988	2b. HOUR	9:15P M
3. SEX	MALE	4. RACE	CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR	MARCH 14 1913
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	5604 POLLARD ROAD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	ENGINEER
12b. KIND OF BUSINESS OR INDUSTRY	NAVY DEPT				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	BETHESDA	YES [ ] NO [ ]	5604 POLLARD ROAD 20816

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
JOSEPH / EDMUND / KING	MARGARET / A. / CULHANE	NO	167-01-2091	GERTRUDE W. KING/WIFE/SAME AS 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pulmonary Metastases of Adenocarcinoma,

DUE TO, OR AS A CONSEQUENCE OF

(c) of unknown primary tumor

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 12.20 19 88 to 12.28 19 88, that (I) (we) last saw the deceased alive on 12.21 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ylene A Larsen MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	12.29.88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Ylene A. Larsen	5454 Wisconsin Ave Chevy Chase Md 20815

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC 31, 1988	GATE OF HEAVEN CEM.	SILVER SPRING MONTGOMERY MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	DEC 30 '88	Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

0 19748 JAN 19 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38241
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
LOWELL	G.	KRAEGEL	DECEMBER 27, 1988	4:45P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	CAUCASIAN	NOV 3 1915	73 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MINNESOTA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	MONTGOMERY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	3606 ISBELL STREET	ADMINISTRATOR	NATL SCIENCE FOUNDATION

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [ ]	3606 ISBELL STREET 20906

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
FREDERICK		KRAEGEL	RUTH		KNUTSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		387-12-6311	AUGUSTA M. KRAEGEL/WIFE/SAME AS 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio respiratory arrest	
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	Pneumonia	
DUE TO, OR AS A CONSEQUENCE OF		
(c)	—	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
[ ]		

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
[ ] [ ]		

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 73, to 12-27-, 19 88, that (I) (we) last saw the deceased alive on 12-19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Alpana Goswami MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALPANA GOSWAMI M.D.	8401 Colesville Road, Silver Spring MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC 30, 1988	NORBECK MEM GARDENS	NORBECK MONTGOMERY MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25. DATE REC'D BY REGISTRAR	26. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	DEC 29 '88	Lucia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The completed removal, carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other than natural, the medical examiner must be notified at once.

BP 1641

DHMH - 16 60M 7/84
(VRA 15, 4)

19830 JAN 20 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

38 38242
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Jeanne	Middle: Anne	Last: Layne	2a. DATE OF DEATH Month: 12 Day: 29 Year: 88	2b. HOUR 2238 PM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: August 4, 1924	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Executive Asst.	12b. KIND OF BUSINESS OR INDUSTRY: Gov't Contractor		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Germantown	YES ☐ NO X	13206 Bristlecone Way #23/20874

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
Clyde / Seymour / Martin	Tanita / Fernandez	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-24-1107
17. INFORMANT: Sandra L. Layne	ADDRESS: 2A Victoria Avenue, Lake Hiawatha NJ 07034	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	1 minute
DUE TO, OR AS A CONSEQUENCE OF (b)	Abdominal carcinomatosis	1 month
DUE TO, OR AS A CONSEQUENCE OF (c)	Ovarian Adenocarcinoma	1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 85 to Dec 27 88, that (I) (we) last saw the deceased alive on Dec 29 19 88, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Christopher Dunford MD	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/30/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Christopher Dunford	22e. ADDRESS: 615 West Montgomery Ave Rockville MD 20850	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	January 3, 1989	National Memorial Park	Falls Church, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850	JAN 03 '89	Julia Davidson-Randall

BP 79

DHMH - 16 50M 1/81 (VRA 15, 4)

19831 JAN 20 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M

DHMH - 17
(VR A15 ME (5))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38243

DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN X / ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Gustavo	B.C.	Machado	12	31	19 88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR
Male	White	July 12, 1973	15 YRS.			12	31	19 88	7:50A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Brazil	Brazil		Montgomery County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Student	School

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS
MD	Montgomery	Bethesda		6208 Verne Street /20817

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ronald	Crivano	Machado	Vera	--	Barrouin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	---	N/A	Luiz Guimaraes, 3006 Mass.Ave,NW,Wash.,DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last	(a) IMMEDIATE CAUSE: Multiple injuries	
	DUE TO, OR AS A CONSEQUENCE OF (b)	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	3:25x 12 31 1988	Pipe bomb explosion

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	garage	4608 Verne Rd.	Bethesda	Mont.	MD

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 1/1/89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial/Transit	1/3/89	Sao Joaõ Batista	Rio de Janeiro, Brazil

24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave,NW,Washington, D.C. 20016

25. DATE REC'D. BY REGISTRAR JAN 03'89

26. REGISTRAR'S SIGNATURE Julia Davidson-Randall

019753 JAN 19 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38244 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 3 and the carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ellis	MIDDLE: W.	LAST: Meeker	2a. DATE OF DEATH MONTH/DAY/YEAR: 12/22/1988	2b. HOUR: 720 P.M.	
3. SEX: M Male	4. RACE: White	5. DATE OF BIRTH MONTH/DAY/YEAR: July 09 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery, Co. MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): Nursing Center 9101 Seed-dtve, Silver Spring, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Orchestra Leader	12b. KIND OF BUSINESS OR INDUSTRY: Entertainment	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Mont.	Bethesda	YES ☒ NO ☐	5012 Worthington Dr. 20816

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Theodore	C.	Meeker	Marie	Wheelock	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		577-05-3420	Mabel Y. Meeker	Same as item # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CONGESTIVE HEART FAILURE, DIABETES MELLITUS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec. 4 19 88 to JAN. 1 19 89, that (I) (we) last saw the deceased alive on Dec. 22 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jerry Allison Snow M.D. DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-22-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JERRY ALLISON SNOW, M.D. — 22e. ADDRESS: 4900 MASSACHUSETTS AVE. NW D.C. 20016

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/6/89	Cedar Hill Cem.	Suitland, MD

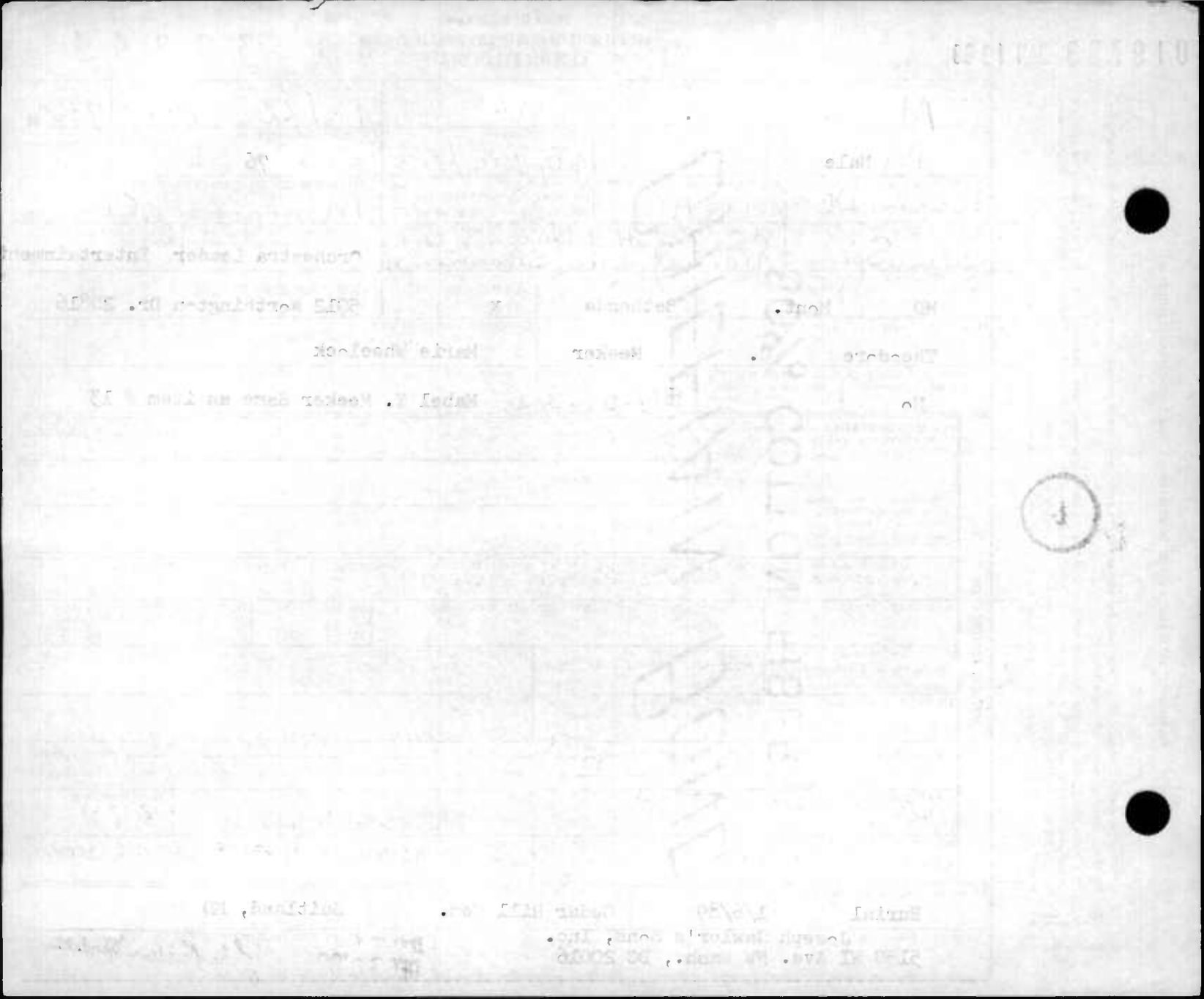
24. FUNERAL DIRECTOR NAME / ADDRESS: Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016

25. DATE REC'D. BY REGISTRAR: DEC 30 '88

25a. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 12

DHMH - 16 60M 7/84 (VRA 15, 4)



016108 DEC 14 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38245

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) First: Betty	Middle: Anesti HNESTIE	Last: Metrenas Metrenas	2a. DATE OF DEATH Month: 12	Day: 9	Year: 88
2b. HOUR: 1112A M					
3. SEX: F	4. RACE: C	5. DATE OF BIRTH Month: 2 Day: 16 Year: 26	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Greece	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: PG	13c. CITY OR TOWN: Chillum	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 6005 10th Place 20783	
14. FATHER'S NAME First: Theodore	Middle:	Last: Anesti	15. MOTHER'S MAIDEN NAME First: Georgia	Middle: Unknown	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 560 34 8332	17. INFORMANT: George Metrenas (Husband)	ADDRESS: Same as 13E	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF (b): CARCINOMATOSIS.

DUE TO, OR AS A CONSEQUENCE OF (c): CARCINOMA OF LEFT LUNG.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): (1) MASSIVE PLEURAL EFFUSION-MALIGNANT (2) PNEUMOTHORAX-LEFT (3) COPD (4) HEART DISEASE (5) CARCINOMA OF BREAST

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-25-, 1986, to 12-9-, 1986, that (I) (we) last saw the deceased alive on 12-6-, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mohammed A. Mannan	DEGREE: M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12-9-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MOHAMMED A. MANNAN	22e. ADDRESS: 3715 RHODE ISLAND AVE MOUNT RAINIER, MD. 20712		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/12/88	23c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln	23d. LOCATION CITY OR TOWN: Brentwood / COUNTY: PG / STATE: Md.
24. FUNERAL DIRECTOR: Hines-Rinaldi 11800 New Hampshire Ave. S.S.Md.		25a. DATE REC'D. BY REGISTRAR: DEC 13 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

019828 JAN 20-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 382246
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Harold T. Miller
2a. DATE OF DEATH MONTH DAY YEAR	12 - 30 - 88
2b. HOUR	2:53 AM
3. SEX	Male
4. RACE	Caucasian
5. DATE OF BIRTH MONTH DAY YEAR	November 18, 1930
6. AGE (IN YEARS LAST BIRTHDAY)	58 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York
7b. CITIZEN OF WHAT COUNTRY?	United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	
9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery County MD.
10. CITY OR TOWN OF DEATH	Bethesda
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Analyst
12b. KIND OF BUSINESS OR INDUSTRY	I.R.S.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	Montgomery
13c. CITY OR TOWN	Silver Spring
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	3811 Chesterwood Drive/20906
14. FATHER'S NAME FIRST / MIDDLE / LAST	Charles E. Miller
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mary Gentilesco
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes
(IF YES, GIVE WAR OR DATES)	Korea
16b. SOCIAL SECURITY NO.	111-22-5157
17. INFORMANT	Ellen M. Miller
ADDRESS	14 West Deer Park Road Gaithersburg, Maryland 20878

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
DUE TO, OR AS CONSEQUENCE OF (b) MULTIPLE ORGAN FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SEVERE GENERALIZED VASCULAR DISEASE

19a. DATE OF OPERATION	11.28.88
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	ANEURYSM OF AORTA
20a. AUTOPSY? YES ☒ NO ☐	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11. 27. 19 88 to 12. 29. 19 88, that (I) (we) last saw the deceased alive on 12. 29. 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Alberto Nunez MD
DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	December 30, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	L. Alberto NUNEZ
22e. ADDRESS	8218 WISCONSIN AVE BETHESDA MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	January 3, 1989	
23c. NAME OF CEMETERY OR CREMATORY	Gate of Heaven Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE	Silver Spring	Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS	Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850	25a. DATE REC'D. BY REGISTRAR	JAN 03 '89	
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall			

BP 15+1

DHMH - 16 50M 1/81 (VRA 15, 4)

0 1 9 8 2 7 JAN 20 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 5 6 3 8 2 4 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen	MIDDLE: H.	LAST: Morgan	2a. DATE OF DEATH MONTH DAY YEAR: December 29, 1988	2b. HOUR: 3:15 a.m.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 17 04	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Model	12b. KIND OF BUSINESS OR INDUSTRY: Fashion		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: MONT.	13c. CITY OR TOWN: Sil. Spg.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 14615 Dreehurst Terr. 20906	
14. FATHER'S NAME FIRST: Daniel	MIDDLE: T.	LAST: Haddock	15. MOTHER'S MAIDEN NAME FIRST: Ella	MIDDLE	LAST: Zimmerman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----	16b. SOCIAL SECURITY NO.: 217-32-1651	17. INFORMANT: Sarah H. Wilkins	32032 Virginia Way S. Laguna, CA	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Haemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Perforation of Duodenal Ulcer, Rheumatoid Arthritis, Alzheimers Disease

19a. DATE OF OPERATION: 11/18/88	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Perforated Ulcer	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from ____, 19 88, to 12/29, 19 88, that (I) ~~(we)~~ last saw the deceased alive on 12/29, 19 88, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Olivia J Lawless	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/29/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): O.J. LAWLESS	22e. ADDRESS: 3801 International Drive Silver Spring		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 1/4/89	23c. NAME OF CEMETERY OR CREMATORY: Mt. Comfort Crematory	23d. LOCATION CITY OR TOWN: Alexandria	COUNTY: VA / STATE
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE REC'D. BY REGISTRAR: JAN 05 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

019752 JAN 19 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33243
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 may be removed for urban papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, either traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jose	MIDDLE: M.	LAST: Musa	2a. DATE OF DEATH MONTH: 12 DAY: 28 YEAR: 88	2b. HOUR: 1000 M	
3. SEX: Male	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: NOV DAY: 12 YEAR: 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CUBA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SILVER SPRING	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 10110 NEW HAMPSHIRE AVE #306	20901
14. FATHER'S NAME FIRST: JOSE MIDDLE: LAST: MUSA			15. MOTHER'S MAIDEN NAME FIRST: ANA MIDDLE: LAST: ARMENTEROS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-58-9512	17. INFORMANT ADDRESS: JUANA MUSA/WIFE/SAME AS 13			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Leukemia - Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis, Leukemia, generalized edema.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, blood dyscrasia - anemia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/5/88 19__ to 12/28/88 19__ that (I) (we) last saw the deceased alive on Dec. 28 1988 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Miguel A. Rodriguez M.D.	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12/28/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MIGUEL A. RODRIGUEZ	22e. ADDRESS: 831 University Blvd. #22. Silver Spring Md. 20903		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: DEC 30, 1988	23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.	23d. LOCATION CITY OR TOWN: SILVER SPRING COUNTY: MONTGOMERY STATE: MD
24. FUNERAL DIRECTOR (OR ADDRESS): FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	25a. DATE REC'D BY REGISTRAR: DEC 29'88	25b. REGISTRAR'S SIGNATURE: Sheila Davidson	

19823 JAN 20 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88 332499 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): FIRST Bruno | MIDDLE Azevedo | LAST Perrone
2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 12 DAY 31 YEAR 1988
2b. HOUR: M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH Nov. DAY 3 YEAR 1970
6. AGE (IN YEARS LAST BIRTHDAY): 18 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 31 YEAR 1988
2d. HOUR: 6:49P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Brazil
7b. CITIZEN OF WHAT COUNTRY? Brazil
8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student
12b. KIND OF BUSINESS OR INDUSTRY: College

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 7800 Beachtree Rd./20817

14. FATHER'S NAME: FIRST Luiz | MIDDLE -- | LAST Perrone
15. MOTHER'S MAIDEN NAME: FIRST Margarida | MIDDLE -- | LAST Azevedo
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ----
16b. SOCIAL SECURITY NO.: None
17. INFORMANT ADDRESS: Luiz Perrone, Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. 3:25 MONTH 12 DAY 31 YEAR 1988
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Pipe bomb explosion
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): garage
21f. LOCATION STREET 4608 Verne Rd. CITY OR TOWN Bethesda COUNTY Mont STATE MD

22a. I certify that I took charge of the remains described above held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ TITLE (SPECIFY) Acting deputy Chief M.D. MEDICAL EXAMINER — DATE SIGNED 1/1/89

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial/Transit
23b. DATE: 1/3/89
23c. NAME OF CEMETERY OR CREMATORY: Jardim Dasaudade
23d. LOCATION CITY OR TOWN Rio de Janeiro COUNTY STATE Brazil

24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016
25a. DATE REC'D BY REGISTRAR: JAN 03 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

019824 JAN 20 89

FOR 1 - STATE REGISTRAR

REG. NO. 88 38250

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Gerard	nmn	Pilon	Dec. 28, 1988	8:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	White	Nov. 27, 1911	77 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Canada	U.S.A.		Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Wheaton	12108 Selfridge Road	Retired/Tool & Die Maker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Wheaton	YES ☒ NO ☐	12108 Selfridge Rd. 20906

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Euclid		Pilon	Anna		Auger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	--------	008-07-9847	Mary nmn Pilon (wife) same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive H Cong Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Years

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 4 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/6, 19 88 to 12/28, 19 88, that (I) (we) last saw the deceased alive on 12/28, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michael E. Leibowitz	11120 New Hampshire Ave. Silver Spring, Md. 20904

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	12/29/88	Metropolitan Crematory	Alexandria, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	DEC 30 '88	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38251

019825 JAN 20 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1a. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
WILLIAM	MARTIN	PREECE	DECEMBER 30, 1988	10:56 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	CAUCASIAN	APRIL 8, 1920	68 YRS		10 / 56
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNSYLVANIA	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING	11005 BURNLEY TERRACE		INSURANCE AGENT	NATIONWIDE	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES [ ] NO [ ]	11005 BURNLEY TERRACE 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
HARRY		PREECE	BERTHA		BREHM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	161-18-5185	PEARL E. PREECE	WIFE SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory arrest.
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic colon Carcinoma -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia, Abnormal liver functions.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1986. 19__, to 12/ 19 88, that (I) (we) last saw the deceased alive on 11/16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Hamid Montakhab	MD	ATTENDING PHYSICIAN [X]	MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	1/3/89.
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS			
HAMID MONTAKHAB, M.D.	6111 EXECUTIVE BLVD. ROCKVILLE, MD. 20852			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	JAN. 3, 1989	PARKLAWN CEMETERY	ROCKVILLE MONTGOMERY MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901	JAN 04 '89	Julia Davidson-Kendall

BP 20+1

DHMH - 16 50M 1/81 (VRA 15, 4)

019821 JAN 20 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

58 38252
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Mildred MIDDLE Orr LAST Regan

2a. DATE OF DEATH: MONTH 12 DAY 29 YEAR 88 — 2b. HOUR 725 A.M.

3. SEX: Female — 4. RACE: Caucasian — 5. DATE OF BIRTH: MONTH 07 DAY 29 YEAR 05 — 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C. — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1009 Nora Dr. Silver Spring — 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Retired secretary - — 12b. KIND OF BUSINESS OR INDUSTRY: bookkeeper

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Montg. — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES ☒ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: 1009 Nora Drive 20904

14. FATHER'S NAME: FIRST John MIDDLE Walker LAST Orr — 15. MOTHER'S MAIDEN NAME: FIRST Edna MIDDLE LAST Burch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): — 16b. SOCIAL SECURITY NO.: 216-44-9597 — 17. INFORMANT: Same as 13E ADDRESS: Joanne Bland (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF
(b): Colon Cancer — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c): Heart Failure — 2 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 9/5/88 — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: mesenteric Thrombosis — 20a. AUTOPSY? YES ☐ NO ☒ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from August 5, 19 86, to December, 19 88, that (I) (we) last saw the deceased alive on Sept 30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did did not view the body after death.

22b. SIGNATURE: Lisa Lillenfield — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lisa Joan Lillenfield, MD — 22e. ADDRESS: 7676 New Hampshire Ave., Langley Pk, Md. #210

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 1/3/89 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven — 23d. LOCATION CITY OR TOWN: S.S. COUNTY: Mont. STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md. — 25a. DATE REC'D. BY REGISTRAR: DEC 30 '88 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84 (VRA 15, 4)

SHELL, FORNEY L.
88/12/17 DR. HALLICK, GALEN 71M MR#701969S

019861 JAN 2 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

88 38253 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN MIDDLE: FORNEY L. LAST: SHELL	2a. DATE OF DEATH MONTH: 12 DAY: 31 YEAR: 88	2b. HOUR 12:55 PM			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 8 DAY: 7 YEAR: 17	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suburban Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret.	12b. KIND OF BUSINESS OR INDUSTRY: Montgomry County School Board		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 11901 Dewey Rd 20906	
14. FATHER'S NAME FIRST: Randal MIDDLE: Edgar LAST: Shell		15. MOTHER'S MAIDEN NAME FIRST: Frances MIDDLE: E. LAST: Crowe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 261-05-7708	17. INFORMANT ADDRESS: Elsie P. Shell (wife) same as 13e			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Irreversible Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Obstructive Pulmonary Disease — Many years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Irreversible Renal Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from December 7, 19 88, to December 31, 19 88, that (I) (we) last saw the deceased alive on December 30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James E Wilson	DEGREE: M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12/31/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): James E. Wilson JR. M.D.	22e. ADDRESS: 11125 Rockville Pike, Ste. 103, Rockville, Md. 20852		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/4/89	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR: JAN 04 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R BP 20+1992

DHMH - 16 50M 1/87 (VRA 15, 4)

019755 JAN 1 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 038254
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10[illegible]

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
EDWARD ALOYSIUS SLATTERY				DECEMBER 26 1988	4:40 A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	CAUCASIAN	MAY 21 1913	75 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED WIDOWED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH		
NEW JERSEY	UNITED STATES		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	NAVAL HOSPITAL		RETIRED	U.S.NAVY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	MONTGOMERY	BETHESDA	YES NO	4956 SENTINEL DRIVE 20816	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
EDWARD ALOYSIUS SLATTERY			MATHILDA FARLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
YES	1942-1970	579-52-8213	MARION E. SLATTERY, 4956 SENTINEL DRIVE, BETHESDA, MD 20816		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(b) ACQUIRED IMMUNE DEFICIENCY SYNDROME
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES X NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES X NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 16, 19 88, to DECEMBER 26, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 26 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Mark S. Georgiadis	MD	X	12/27/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
MARK S. GEORGIADIS, LT, MC, USNR	NAVAL HOSPITAL BETHESDA, MD 20814-5011		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL	Dec.29,1988	Arlington National Cem	Arlington VA.	
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
DeVol Funeral Home	2222 Wisc. Ave. Washington D.C.	DEC 30 '88	Julia Davidson-Randall	

019900 JAN 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38255
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Edmonde' Middle Guy Last Sorenson

2a. DATE OF DEATH: Month 12 Day 30 Year 88 — 2b. HOUR: 455 A.M.

3. SEX: female

4. RACE: Caucasian

5. DATE OF BIRTH: Month 10 Day 24 Year 24

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ray, Arizon

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: MONT — MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3207 Hewitt Ave Silver Spring

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Seamstress

12b. KIND OF BUSINESS OR INDUSTRY: Clothing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Montg. — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 3207 Hewitt Ave S.S., MD

14. FATHER'S NAME: First Guy Middle Last Wilcox

15. MOTHER'S MAIDEN NAME: First Enez Middle Fannie Last Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES): No

16b. SOCIAL SECURITY NO.: 505-26-7202

17. INFORMANT: Roxanne Wilson — ADDRESS: Rt.1 Vertran, Wy. 82243

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic Encephalopathy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Cancer of

DUE TO, OR AS A CONSEQUENCE OF (c): Unknown Origin

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES ☐ NO ☐ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ — 21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to Dec 19 88, that (I) (we) last saw the deceased alive on Dec 15 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-30

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Frederick Smith

22e. ADDRESS: 5401 Western Ave. Washington, D.C. 20015

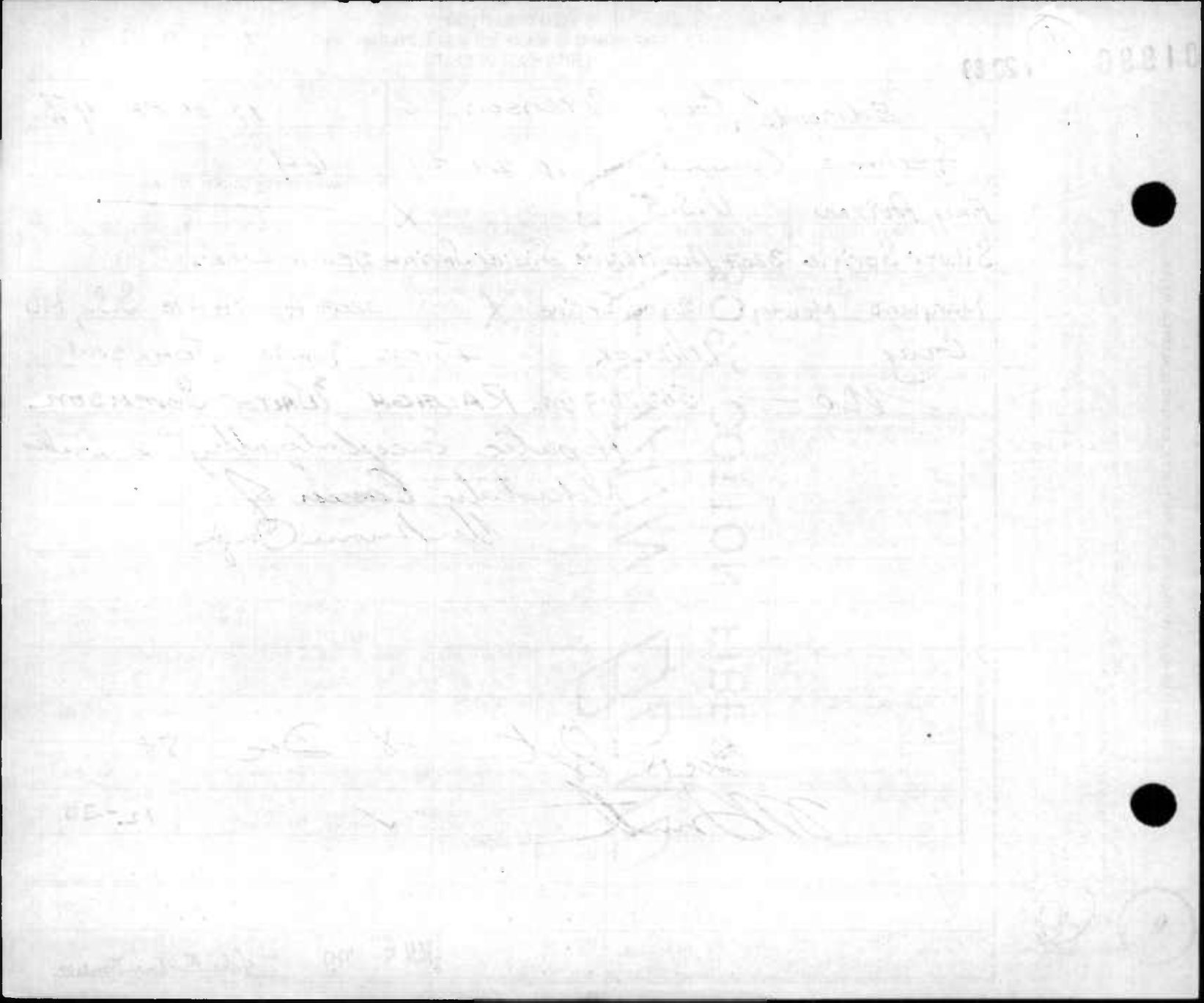
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 12/30/88 — 23c. NAME OF CEMETERY OR CREMATORY: Balto.Wash.Crematory — 23d. LOCATION: CITY OR TOWN Laurel, COUNTY P.G., STATE Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR: JAN 5 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16.60M 7/84
(VRA 15, 4)



013973 NOV 18 '88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 338256

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Joy — MIDDLE: T. — LAST: Spruill

2a. DATE OF DEATH — MONTH DAY YEAR: 11-13-88

2b. HOUR: 11:20 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: aug-6-1924

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): No. Carolina

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montg. MD.

10. CITY OR TOWN OF DEATH: Takoma Park.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Reg. Nurse.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: P. George.

13c. CITY OR TOWN: Hyattsville

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS | ZIP CODE: 9014-Adelphi Rd. 20783

14. FATHER'S NAME — FIRST MIDDLE LAST: Ernest N. Darnell.

15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Beulah Poindexter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b. SOCIAL SECURITY NO.: 225-26-5155

17. INFORMANT — ADDRESS: Milford Spruill (13E)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Renal failure — WKS

DUE TO, OR AS A CONSEQUENCE OF (c): Congestive Heart Failure — WKS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Asymptomatic Rheumatic Heart Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept. 19 15 to Nov 13 19 88, that (I) (we) last saw the deceased alive on Nov 13 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert K. Dahlman — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 11/13/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT K. DAHLMAN MD

22e. ADDRESS: 1106 Spring St. Silver Spring MD

IMPORTANT: Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Nov. 17-1988

23c. NAME OF CEMETERY OR CREMATORY: Forge Washington

23d. LOCATION (CITY OR TOWN, COUNTY, STATE): Riggs Rd. P. Geo. Md. 20706

FUNERAL DIRECTOR (NAME): Arthur Matters — 254 Takoma Funeral Home, Carroll St. N. W. D. C.

25a. DATE REC'D. BY REGISTRAR: NOV 17 1988

25b. REGISTRAR'S SIGNATURE:

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

0 19860 JAN 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38257

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH / ESTIMATED	2b. HOUR
JUNE	E	TANIS	MONTH DAY YEAR: Dec 24 1988	2:37 PM

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR)	2d. HOUR
F	W	May 24 26	62 YRS.			Dec 24 1988	2:41 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash. D.C.	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Sil. Spg.	Holy Cross Hosp	Homemaker	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Mont.	Sil. Spg.	YES ☐ NO ☒	12402 Ellen Ct.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George		Huber	Susie	E	Kneisley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A		579 24 7169	Peter Tanis (Husband) Same as 13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Dis.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocardial Dis

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John L. Rogers M.D. TITLE (SPECIFY) Dep MEDICAL EXAMINER DATE SIGNED Dec 28 1988

EXAMINER'S NAME (TYPE OR PRINT) Dr. John Rogers ADDRESS 1919 Seminary Rd. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	12/31/88	Gate of Heaven	S.S.	Mont.	Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md	DEC 30 '88	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DHMH - 17
(VR A15 ME (5))

019857 JAN 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38258

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. DECEASED NAME (TYPE OR PRINT) First: Kathryn	Middle: V.	Last: Viands	2a. DATE OF DEATH Month: 12	Day: 30	Year: 1988
2b. HOUR: 945 PM					
3. SEX: Fe	4. RACE: CAUCASIAN	5. DATE OF BIRTH Month: 11	Day: 17	Year: 1924	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	MONTGOMERY	SILVER SPRING	YES ☐ NO ☒	1013 ARCOLA AVENUE 20902

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WALTER	E.	HYNSON	FLORENCE	R.	STEVENS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		578-30-4766	DAUGHTER GLORIA BYNAKER	4700 BOILING BROOK PKWY ROCKVILLE, MD 20852

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC LUNG CANCER

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 12/25 19 88 to 12/30 19 88 that (I) (we) last saw the deceased alive on 12/30 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
David I Woronow MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	1/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANIEL I WORONOW, MD	344 UNIVERSITY BLVD, W #213 SILVER SPRING, MD 20901

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	JAN 3, 1989	GATE OF HEAVEN CEM.	SILVER SPRING MONTGOMERY MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	JAN 04'89	Lucia Davidson-Randolph

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

19858-JAN 20 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 382599 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Theodore	John	Vornbrock	December 28, 1988	3:20 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	March 9,1942	46 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Minnesota	United States		Montgomery County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Gaithersburg	20219 Maple Leaf Court	Computer Programmer/Systems	Computer

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Gaithersburg	YES [ ] NO [X]	20219 Maple Leaf Court / 20874

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Augustine	Vornbrock	Jennie	M.	Stokvis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	1961-1964	473-46-2561	John A. Vornbrock, Jr. 1257 E. Burke Ave., Maplewood, MN. 55109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sarcoma	
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [XX]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (XXXXXX) attended the deceased from March 18, 19 87, to December 28 19 88, (XX) (we) last saw the deceased alive on Sept. 22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. [X] (we) (XX) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James H Brodsky Covering for Dr. S. Newman	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	Dec. 28, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James H. Brodsky, M.D.	4701 Willard Ave., #224, Chevy Chase, MD 20815

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial/Transit	December 28, 1988	Resurrection Cemetery	St. Paul / Minnesota

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue, Rockville, MD.	DEC 30 '88	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

RO HOSPITAL BP 1241

DHMH - 16 50M 1/81 (VRA 15, 4)

019743 JAN 19 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38260 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Amos / M / White	2a. DATE OF DEATH — MONTH DAY YEAR	12 27 1988	2b. HOUR	20:47 M
3. SEX	M	4. RACE	C	5. DATE OF BIRTH — MONTH DAY YEAR	08 01 1921
6. AGE (IN YEARS LAST BIRTHDAY)	67 YRS	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	OHIO	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	WASHINGTON ADVENTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	GEOLOGIST
12b. KIND OF BUSINESS OR INDUSTRY	US GEOL. SURVEY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD.	13b. COUNTY	PRINCE GEORGE	13c. CITY OR TOWN	COLLEGE PARK
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]		13e. STREET ADDRESS	6100 WESTCHESTER PARK DR. 20740		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	PHILIP / T. / WHITE	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	GLADYS / McNARY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	YES	IF YES, GIVE WAR OR DATES	WW II	16b. SOCIAL SECURITY NO.	288-18-7811
17. INFORMANT — ADDRESS	DOROTHY WHITE SAME AS 13e				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Respiratory Failure — 3 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Ascites — 1 Week

DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Adenocarcinoma of Lung — 1 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/21, 19 88, to 12/27, 19 88, that (I (we) last saw the deceased alive on 12/27/88, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Alfred Munzer	DEGREE M.D. — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED 12/28/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Alfred Munzer M.D.	22e. ADDRESS	7600 Carroll Avenue Takoma Park, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	CREMATION	23b. DATE	12-28-88	23c. NAME OF CEMETERY OR CREMATORY: METROPOLITAN CREMATORY
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	ALEXANDRIA / VA.			
24. FUNERAL DIRECTOR — NAME, ADDRESS	FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD. 20901	25a. DATE RECD. BY REGISTRAR DEC 29 '88	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

20 records BP 20

DHMH - 16 50M 1/81 (VRA 15, 4)

019855 JAN 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33261
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Beverly	MIDDLE: A.	LAST: Widmayer	2a. DATE OF DEATH MONTH DAY YEAR: 12 26 1988	2b. HOUR: 1356	M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 9 1952	6. AGE (IN YEARS LAST BIRTHDAY): 36 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S. A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County	MD.	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): clerk	12b. KIND OF BUSINESS OR INDUSTRY: retail		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: P.G.	13c. CITY OR TOWN: District Hght	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS / ZIP CODE: 6612 Atwood Street #6 20747	
14. FATHER'S NAME FIRST: George	MIDDLE: E.	LAST: Widmayer	15. MOTHER'S MAIDEN NAME FIRST: Alma	MIDDLE: A.	LAST: Widmayer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	IF YES, GIVE WAR OR DATES: ----------	16b. SOCIAL SECURITY NO.: 218 54 8435	17. INFORMANT MD 20747 ADDRESS: George Widmayer/2409 Kirtland Ave/Forestville		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hrs.
DUE TO, OR AS A CONSEQUENCE OF: (b): metastatic malignant melanoma — mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF: (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from January 19 88, to Dec 26 19 88, that (I) (we) last saw the deceased alive on 12/26 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.

22b. SIGNATURE: Martin D. Welt — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/26/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN D. WELT 7525 — 22e. ADDRESS: Greenway Ct Dr Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Dec 29 1988	23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery	23d. LOCATION CITY OR TOWN: Clinton	COUNTY: P.G.	STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Robert E. Wilhelm Funeral Home Suitland MD		25a. DATE REC'D. BY REGISTRAR: JAN 05 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH - 16 60M 7/84 (VRA 15, 4)

FEE $10.00

019854 JAN 2 2 '89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 33262

4. DECEASED NAME (TYPE OR PRINT): FIRST VIVIAN; MIDDLE B.; LAST WILHITE

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 12 DAY 31 YEAR 1988 — 2b. HOUR 0300 M

3. SEX: F — 4. RACE: C — 5. DATE OF BIRTH: MONTH 03 DAY 16 YEAR 03 — 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 31 YEAR 1988 — 2d. HOUR 0500 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ARKANSAS

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD

10. CITY OR TOWN OF DEATH: BETHESDA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SUBURBAN HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): GOVERNMENT EMPLOYEE

12b. KIND OF BUSINESS OR INDUSTRY: U.S. GOV'T.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: MONTGOMERY — 13c. CITY OR TOWN: BETHESDA — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 6409 HOLLINS DR 20817

14. FATHER'S NAME: FIRST WILLIAM; MIDDLE A.; LAST BYRD

15. MOTHER'S MAIDEN NAME: FIRST MARY; MIDDLE ELIZABETH; LAST BOONE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): NONE

16b. SOCIAL SECURITY NO.: 248-09-6361

17. INFORMANT: MARILYN CHIPCHIN — ADDRESS: 6409 HOLLINS DRIVE BETHESDA MD. 20817

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	ACUTE
DUE TO, OR AS A CONSEQUENCE OF (b)	MULTIPLE SYSTEM FAILURE	28 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	FRACTURED RIGHT HIP	29 DAYS

888

Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CHRONIC LYMPHATIC LEUKEMIA

19a. DATE OF OPERATION: 12/03/88 — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? FRACTURED Rt HIP — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH 12 DAY 02 YEAR 1988 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): FELL AT HOME

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): HOME — 21f. LOCATION STREET 6409 HOLLINS DR CITY OR TOWN BETHESDA COUNTY MONT STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Francis C Mayle M.D. — TITLE (SPECIFY): DEPT MEDICAL EXAMINER — DATE SIGNED: 12/31/88

EXAMINER'S NAME (TYPE OR PRINT): FRANCIS C MAYLE — ADDRESS: 8210 WISCONSIN AVE BETHESDA MD 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: JAN. 4, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY — 23d. LOCATION CITY OR TOWN SUITLAND COUNTY PGCO STATE MARYLAND

24. FUNERAL DIRECTOR NAME AND ADDRESS: ROBERT E. WILHELM, INC. SUITLAND, MARYLAND — 25a. DATE REC'D. BY REGISTRAR: JAN 05'89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

R 12/84 BP

DHMH - 17
(VR A15 ME (5))

019852 JAN 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38263

1. DECEASED NAME (TYPE OR PRINT) — FIRST: LAURA — MIDDLE: O. — LAST: ZIMMERMAN

2a. DATE OF DEATH (MONTH DAY YEAR): 12-27-88

2b. HOUR: 2235 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH (MONTH DAY YEAR): 11-18-06

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Vermont

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.

10. CITY OR TOWN OF DEATH: ROCKVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SHADY GROVE ADVENTIST

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: MONTG

13c. CITY OR TOWN: ROCKVILLE

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 201582 1702 VIERS MILL RD

14. FATHER'S NAME — FIRST: Leslie — MIDDLE — LAST: Pike

15. MOTHER'S MAIDEN NAME — FIRST: Katie — MIDDLE — LAST: Waters

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. IF YES, GIVE WAR OR DATES: -----

16b. SOCIAL SECURITY NO.: 058-12-4747

17. INFORMANT — ADDRESS: Constance Frenette (daughter) 29 Westbrook Rd. So.Hadley, Mass. 01075

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Emphysema; COPD

DUE TO, OR AS A CONSEQUENCE OF (c): congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Recurrent aspiration pneumonia

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-5-19 88 to 12-27-19 88, that (I) (we) last saw the deceased alive on 12-27-19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S. Sudhakar, M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12-28-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. SUDHAKAR

22e. ADDRESS: 50 W EDMONSTON DR., ROCKVILLE MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12/30/88

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park

23d. LOCATION CITY OR TOWN: Rockville, Md. COUNTY STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852

25a. DATE REC'D BY REGISTRAR: DEC 30 '88

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 14

DHMH - 16.50M 1/81 (VRA 15, 4)

0216188 FEB 3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 38264
REG. NO.

CLEARED by MEDICAL EXAMINER - Dr J. Boyd

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	HAZEL C. BENTON	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 6, 1988	2b. HOUR	5:45P M
3. SEX	FEMALE	4. RACE	CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR	FEB 9 1919
6. AGE (IN YEARS LAST BIRTHDAY)	69 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	TENNESSEE	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGES 16 MD.				
10. CITY OR TOWN OF DEATH	RIVERDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	LELAND MEM HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PR GEORGES	HYATTSVILLE	YES [X] NO [ ]	3915 CALVERTON DRIVE 20782

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
BLAKELY SAYLORS	LULA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	251-16-4349	CHARLES BENTON/HUSBAND/SAME AS 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) COPD

DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from NOVEMBER 3, 19 88, to NOVEMBER 6, 19 88, that (I) (we) last saw the deceased alive on NOVEMBER 3, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	11/4/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARK PARKHURST, MD	7305 BALT AVENUE COLLEGE PARK, MD 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	NOV 9,1988	PARKLAWN CEMETERY	ROCKVILLE MONTGOMERY MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	NOV 21 1988	[signature]

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

19893 JAN 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 38265

1. DECEASED NAME (TYPE OR PRINT): FIRST Frances MIDDLE Irene LAST Brown

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 12 DAY 26 YEAR 1988 — 2b. HOUR

3. SEX: Female — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 10 DAY 24 YEAR 18 — 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 26 YEAR 1988 — 2d. HOUR 1733 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Goe's General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Prince Geo — 13c. CITY OR TOWN: Capital Hgts — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 6810 Central Ave. #102 20743

14. FATHER'S NAME: FIRST Isaac MIDDLE Brown LAST

15. MOTHER'S MAIDEN NAME: FIRST Isabelle MIDDLE Scott LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217 36 7590

17. INFORMANT: John Brown — ADDRESS: 8106 Phelps Pl. Forestvle MD. 20747

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Disseminated cerebro-cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 12-27-88

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 31 Dec 88 — 23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem — 23d. LOCATION CITY OR TOWN: Clinton, P.G. Co., MD

24a. FUNERAL DIRECTOR: Martell Adams, Aquasco MD 20608 — 25a. DATE REC'D. BY REGISTRAR: JAN 6 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Rondeau

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 25M BP 3 DH 17

(VR A15 ME (5))

J20583 JAN 25 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

5 8 3 8 2 6 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST MARY MIDDLE E. LAST CALOMERIS

2a. DATE OF DEATH: MONTH 12 DAY 19 YEAR 88

2b. HOUR 3:30 P M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH Nov. DAY 28, YEAR 1909

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.

10. CITY OR TOWN OF DEATH: CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker

12b. KIND OF BUSINESS OR INDUSTRY: home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Charles

13c. CITY OR TOWN: Bryantown

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: P.O. Box 399 20617

14. FATHER'S NAME: FIRST L. MIDDLE LAST Cornell

15. MOTHER'S MAIDEN NAME: FIRST Ada MIDDLE LAST unk.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES): n/a

16b. SOCIAL SECURITY NO.: 226-44-7978

17. INFORMANT: Barbara Calomeris ADDRESS: same as 13 a-e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Severe atherosclerotic coronary heart — dis.years.

DUE TO, OR AS A CONSEQUENCE OF (c): left frontal brain tumor. — months.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MA
UROSEPSIS, EPISODE OF HYPOTENSION, MULTIINFARCTION DEMENTIA, EMPHYSI

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1988, to Dec. 19, 1988, that (I) (we) last saw the deceased alive on Dec. 19, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: DEC.19 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PETER W.YIM M.D.

22e. ADDRESS: 7900 OLD BRANCH AVE. SUITE 101 CLINTON, MARYLAND 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Dec.20,1988

23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory

23d. LOCATION: CITY OR TOWN Clinton, COUNTY Prince Georges STATE MD

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. ADDRESS: 6633 Old ALexander Ferry Rd., CLinton, MD 20735

25a. DATE REC'D BY REGISTRAR: DEC 22 1988

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN:

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

007919 SEP 22 88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38267

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then tease remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: mildred	MIDDLE	LAST: CLark	2a. DATE OF DEATH MONTH DAY YEAR: 9/11/88	2b. HOUR: 12:10 PM	
3. SEX: female	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: 9 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: D.C. Grant MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: VA.	13b. COUNTY: Westmoreland	13c. CITY OR TOWN: Montross	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt. 1, Box 3120	
14. FATHER'S NAME FIRST: JOHN MIDDLE: LEWIS LAST: SANFORD		15. MOTHER'S MAIDEN NAME FIRST: HATTIE MIDDLE: DOLEMAN LAST:			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-62-7891	17. INFORMANT: Mrs. Mildred Brennan	ADDRESS: 2510 Larry Ave. Ft. Washington, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure & Cardiac Arrest	24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Artery Disease	Yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerotic Cardiovascular Disease	Yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~have hospital~~) attended the deceased from May, 19 84, to Sept 11, 19 88, that (I) (~~saw~~) last saw the deceased alive on Sept 10, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: T. Keenan L. Fredson	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Sept 11, 1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9/14/88	23c. NAME OF CEMETERY OR CREMATORY: Providence	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Montross, Westmoreland Co., Va.	
24. FUNERAL DIRECTOR NAME AND ADDRESS: Welch Funeral Home, Box 373, Montross, Va. 22520		25a. DATE REC'D BY REGISTRAR: SEP 21 1988	25b. REGISTRAR'S SIGNATURE: Jane Davidson Randall	

BP

DHMH - 16 SDM 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

019580 JAN 1989

REG. NO. 88 36263

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST LAVINA MIDDLE J. LAST DIEL

2a. DATE OF DEATH: MONTH 12 DAY 30 YEAR 88 — 2b. HOUR 11:10 P.M.

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH Aug DAY 28, YEAR 1891

6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES Co, MD.

10. CITY OR TOWN OF DEATH: HYATTSVILLE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CARROLL MANOR NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNAUTHORIZABLE

12b. KIND OF BUSINESS OR INDUSTRY: —

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: NONE — 13b. COUNTY: NONE — 13c. CITY OR TOWN: WASH. D. C. — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 1610 PARK Rd. NW 20010

14. FATHER'S NAME: FIRST JACOB MIDDLE LAST DIEL

15. MOTHER'S MAIDEN NAME: FIRST MARGARET MIDDLE LAST FLETON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-18-2935

17. INFORMANT: JAMES C. TOOMEY — ADDRESS: 4982 SENTINEL DR. BETHESDA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): ACUTE CONGESTIVE HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b): BILATERAL BRONCHO PNEUMONIA — 5 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ATHEROSCLEROTIC CARDIORENAL VASCULAR DISEASE

19a. DATE OF OPERATION: — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20a. AUTOPSY? YES ☐ NO ☒ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~the hospital~~) attended the deceased from JANUARY 1 19 87 to DECEMBER 30 19 88, that (I) (~~was~~ last saw the deceased alive on DECEMBER 30 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was not~~) (did not) view the body after death.

22b. SIGNATURE: Marta A. Schneider MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTA A. SCHNEIDER MD — 22e. ADDRESS: 3401 MACARTHUR BLVD NW WASH DC 20016

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: JAN. 4, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM. — 23d. LOCATION CITY OR TOWN: WASHINGTON COUNTY STATE D.C.

24. FUNERAL DIRECTOR NAME: DeVOL FUNERAL HOME WASH. D.C. — John F. DeVol

25a. DATE REC'D BY REGISTRAR: JAN 17 1989 — 25b. REGISTRAR'S SIGNATURE

10 HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

019890 JAN 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 3 3 2 6 9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: PHILLIP Middle: Harron Last: GRAY				2a. DATE OF DEATH Month Day Year: 12-27-88	2b. HOUR: 2406 M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH Month Day Year: 12 3 27	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES CO. MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SO. MARYLAND HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Geo	Brandywine	YES ☒ NO ☐	15011 Brandywine Rd. 20613

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Lawrence Gray	Dorothy C. Newman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	216 09 3332	Lowell Gray	SAA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiac arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	metastatic cancer of the rectum	4 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/27 19 88 to 12/27 19 88 that (I) (we) last saw the deceased alive on 12/26 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Carlos Alvarado	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CARLOS ALVARADO	7500 St Barnabas Rd Oxon Hill MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/ 31/88	Resurrection Cem	Clinton, P.G.Co., MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Martell Adams, Aquasco Md.	JAN 4 '89	[signature] Randall

BP

DHMH - 10-30M 1/81 (VRA 15, 4)

19897 JAN 20 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

S 8 3 8 2 7 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: FRANK	MIDDLE: MARTIN	LAST: GRIFFIN SR.	2a. DATE OF DEATH MONTH DAY YEAR: 12-28-88	2b. HOUR: 11 47 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JAN 8, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN ONE, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DISTRIBUTOR	12b. KIND OF BUSINESS OR INDUSTRY: WASH. POST NEWSPAPER		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	P.G.C.	HYATTSVILLE	YES [X] NO [ ]	5026 54th PL. 20781

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
FRANKLIN MARTIN GRIFFIN SR.	THERESA HUNGERFORD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16a. (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	----------	578-18-0104	TERESA M. GRIFFIN	(SAME AS ITEM #13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Cardiac arrhythmia	
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic heart disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Myxhadopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 12/28/88 19 88, to 12/28/88 19 88, that (I) (we) last saw the deceased alive on 12/28/88 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S. Punja — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 12-30-1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. PUNJA — 22e. ADDRESS: PG Hospital Cheverly MD 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	1-3-1989	FT. LINCOLN CEMETERY	BRENTWOOD, P.G.C. Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO.	RIVERDALE, MD. 20737	JAN 5 '89	Lelia Tuvis [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - [illegible] 1/81 (VRA [illegible])

Items 13a-e per birth Cert. 11/17/88 DAD

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

S 8 3 8 2 7 1
REG. NO.

012356 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (First, Middle, Last)	2a. DATE OF DEATH (Month, Day, Year)	2b. HOUR
Baby A/K/A Benjamin Harlan HARLAN	10 1 88	6:30 AM

3. SEX	4. RACE	5. DATE OF BIRTH (Month, Day, Year)	6. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	White	10 1 88	YRS		2 / 45

7a. BIRTHPLACE (State or Foreign Country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	PRINCE GEORGE MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address)	12a. USUAL OCCUPATION (Type of work for most of working life)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE Hosp. Center	-	-

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Pr. Geo.	WHITE MARSH	YES ☐ NO ☐	13131 MANOR DR 21771

14. FATHER'S NAME (First, Middle, Last)	15. MOTHER'S MAIDEN NAME (First, Middle, Last)
Enoch Andrew Harlan	SARAH - Kruit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown)	(If yes, give war or dates)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	-	Mr. Enoch A. Harlan	13131 Manor Dr. 21771

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

Approximate interval between onset and death:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY (Hour A.M. P.M., Month, Day, Year 19)	21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)	21f. LOCATION (Street / City or Town / County / State)
While at work ☐ Not while at work ☐		

22a. I certify that (I) (this hospital) attended the deceased from 10/1/88, 19 88, to 10/1, 19 88, that (I) (we) last saw the deceased alive on 10/1/88, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Avraham Kadar	MD — Attending Physician ☑ Medical Director ☐ Staff Physician ☐	10/1/88

22d. PHYSICIAN'S NAME (Type or Print)	22e. ADDRESS
AVRAHAM KADAR	325 CHARLES St. ROCKVILLE MD 20850

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town / County / State)
Burial	10-4-88	Arlington Baptist Cem.	Randallstown Balto. Md.

24. FUNERAL DIRECTOR (Name / Address)	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bryan W. Clary 10 W. Padonia Rd.	OCT 6 1988	

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 13a - e per birth Cert. 11/7/88 DHD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

88 38272
REG. NO.

012349 NOV -4 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Baby Boy	AKA Beth	Last: Harlan HARLAN	2a. DATE OF DEATH Month: 10 Day: 1 Year: 88	2b. HOUR 6:30 A.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month: 10 Day: 1 Year: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours: 2 Min.: 45
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE	MD.	
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE Hosp. Center.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): -	12b. KIND OF BUSINESS OR INDUSTRY: -		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Fred.	13c. CITY OR TOWN: Mt. Airy	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 13131 Manor Dr. 21771	
14. FATHER'S NAME First: Enoch Middle: Andrew Last: Harlan		15. MOTHER'S MAIDEN NAME First: SARAH Middle: - Last: Kruit			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): . (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: -	17. INFORMANT: Mr. Enoch A. Harlan	ADDRESS: 13131 Manor Dr. 21771		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/1 19 88 to 10/1 19 88, that (I) (we) last saw the deceased alive on 10/1 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Avraham Kadar	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/1/88.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): AVRAHAM KADAR	22e. ADDRESS: 325 CHARLES ST. Rockville Md. 20850		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10-4-88	23c. NAME OF CEMETERY OR CREMATORY: Arlington Baptist Cem.	23d. LOCATION CITY OR TOWN: Randallstown COUNTY: Balto. STATE: Md.	
24. FUNERAL DIRECTOR NAME: Bryan W. Clary	ADDRESS: 10 W. Padonia Rd.	25a. DATE REC'D. BY REGISTRAR: OCT 6 1988	25b. REGISTRAR'S SIGNATURE: [signature] Registrar	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 13a - e per birth cert. 11/17/88 DHD

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

012352 NOV 88

88 33273
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Baby G MIDDLE AKA Charity LAST Harlan HARLAN

2a. DATE OF DEATH: MONTH 10 DAY 1 YEAR 88

2b. HOUR: 6:40 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 10 DAY 1 YEAR 88

6. AGE (IN YEARS LAST BIRTHDAY): YRS — IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS 2 MIN. 36

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.

10. CITY OR TOWN OF DEATH: Cheverly

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George Hosp. Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): -

12b. KIND OF BUSINESS OR INDUSTRY: -

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Fred

13c. CITY OR TOWN: Mt. Airy

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 13131 Manor Dr. 21771

14. FATHER'S NAME: FIRST Enoch MIDDLE Andrew LAST Harlan

15. MOTHER'S MAIDEN NAME: FIRST SARAH MIDDLE LAST Kruit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): -

16a. (IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: -

17. INFORMANT / ADDRESS: Mr. Enoch A. Harlan, 13131 Manor Dr., 21771

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/1/88 to 10/1/88, that (I) (we) last saw the deceased alive on 10/1/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Avraham Kadar DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): AVRAHAM KADAR

22e. ADDRESS: 325 CHARLES St Rockville Md 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/4/88

23c. NAME OF CEMETERY OR CREMATORY: Arlington Baptist Cem

23d. LOCATION: CITY OR TOWN Randallstown COUNTY Balto. STATE Md.

24. FUNERAL DIRECTOR: Bryan W. Clary ADDRESS: Bryan W. Clary, 10 W. Padonia Rd., 21093

25a. DATE REC'D. BY REGISTRAR: OCT 6 1988

25b. REGISTRAR'S SIGNATURE: Lia Davidson-Landers

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must report to the police.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

012353 NOV 88

Items 13a-e per birth cert. 11/17/88 DAD

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38274
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Baby — MIDDLE: E — LAST: HARLAN
AKA Charles Harlan

2a. DATE OF DEATH — MONTH: 10 — DAY: 1 — YEAR: 88
2b. HOUR: 6:45A M

3. SEX: Male
4. RACE: White
5. DATE OF BIRTH — MONTH: Oct. — DAY: 1 — YEAR: 1988
6. AGE (IN YEARS LAST BIRTHDAY) — YRS.
IF UNDER 1 YEAR — MONTHS: — DAYS:
IF UNDER 24 HRS. — HOURS: 2 — MIN.: 48

3a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE George. MD.

10. CITY OR TOWN OF DEATH: Cheverly
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George Hosp. Center.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): -
12b. KIND OF BUSINESS OR INDUSTRY: -

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Fred.
13c. CITY OR TOWN: Mt. Airy
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 13131 Manor Dr. 21771

14. FATHER'S NAME — FIRST: Enoch — MIDDLE: Andrew — LAST: Harlan
15. MOTHER'S MAIDEN NAME — FIRST: SARAH — MIDDLE: — LAST: Kruit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): -
(IF YES, GIVE WAR OR DATES): -
16b. SOCIAL SECURITY NO.: -
17. INFORMANT — ADDRESS: Mr. Enoch A. Harlan, 13131 Manor Dr., 21771

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cleft Lip / Palate.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/1 19 88 to 10/1 19 88, that (I) (we) last saw the deceased alive on 10/1 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Abraham Kadar
DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/1/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): AVRAHAM KADAR
22e. ADDRESS: 325 CHARLES St, Rockville Md 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/4/88
23c. NAME OF CEMETERY OR CREMATORY: Arlington Baptist Cem.
23d. LOCATION — CITY OR TOWN: Randallstown — COUNTY: Balto. — STATE: Md.

24. FUNERAL DIRECTOR — NAME: Bryan W. Clary — ADDRESS: 10 W. Padonia Rd., 21093
25a. DATE REC'D. BY REGISTRAR: OCT 6 1988
25b. REGISTRAR'S SIGNATURE: Lisa Dawson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 13a-e per birth cert. 11/17/88 DAD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 38275
REG. NO.

01235 NOV 4 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby	MIDDLE: F	LAST: AKA Edward Harlan HARLAN	2a. DATE OF DEATH MONTH DAY YEAR: 10-01-88	2b. HOUR: 6:30A M
3. SEX: Male.	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 1 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS / DAYS: — / HOURS 2 / IF UNDER 24 HRS. MIN. 29
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE George Hosp. Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Pr. Geo.	Mt. Rainier	YES ☐ NO ☐	13131 Manor Dr 20771

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	
Enoch	Andrew	Harlan	SARAH		Kruit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
—	—	—	Mr. Enoch A. Harlan, 13131 Manor Dr., 21771

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/10/88 to 10/1/88, that (I (we) last saw the deceased alive on 10/1/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Avraham Kadar	M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
AVRAHAM KADAR	325 Charles St. Rockville Md 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/4/88	Arlington Baptist Cem.	Randallstown Balto. Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bryan W. Clary, 10 W. Padonia Rd. 21093	OCT 6 1988	Linda Davidson-Lindsay

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 13a - e per birth cert. 11/17/88 DHD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

88 33276
REG. NO.

01235 I NOV 88

1. DECEASED NAME (TYPE OR PRINT): FIRST Baby D AKA: Joy MIDDLE Harlan LAST #HARLAN

2a. DATE OF DEATH: MONTH 10 DAY 1 YEAR 88

2b. HOUR: 6:30 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Oct. DAY 1 YEAR 1988

6. AGE (IN YEARS LAST BIRTHDAY): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS 2 MIN. 33

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.

10. CITY OR TOWN OF DEATH: Cheverly

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George Hosp. Center.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —

12b. KIND OF BUSINESS OR INDUSTRY: —

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Fred.

13c. CITY OR TOWN: Mt. Airy

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: 13131 Manor Dr. 21771

14. FATHER'S NAME: FIRST Enoch MIDDLE Andrew LAST Harlan

15. MOTHER'S MAIDEN NAME: FIRST SARAH MIDDLE — LAST Kruit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): —

16b. (IF YES, GIVE WAR OR DATES): —

16c. SOCIAL SECURITY NO.: —

17. INFORMANT ADDRESS: Mr. Enoch A. Harlan, 13131 Manor Dr., 21771

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/10/88 to 10/1/88, that (I) (we) last saw the deceased alive on 10/1/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Avraham Kadar DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): AVRAHAM KADAR

22e. ADDRESS: 325 CHARLES ST. Rockville, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/4/88

23c. NAME OF CEMETERY OR CREMATORY: Arlington Baptist Cem.

23d. LOCATION: CITY OR TOWN Randallstown COUNTY Balto. STATE Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Bryan W. Clary, 10 W. Padonia Rd., 21093

25a. DATE REC'D. BY REGISTRAR: OCT 6 1988

25b. REGISTRAR'S SIGNATURE: Freidon Lindsay

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 13a - 2 per birth cert. 11/17/88 DAD

012350 NOV 88

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38277
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Baby C. | MIDDLE: A'KA' Patience | LAST: Harlan HARLAN

2a. DATE OF DEATH — MONTH: 10 | DAY: 1 | YEAR: 88

2b. HOUR: 6:30 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: 10 | DAY: 1 | YEAR: 88

6. AGE (IN YEARS LAST BIRTHDAY): YRS. | IF UNDER 1 YEAR — MONTHS, DAYS | IF UNDER 24 HRS. — HOURS: 2 | MIN.: 34

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE George. MD.

10. CITY OR TOWN OF DEATH: Cheverly

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George Hosp. Center.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): -

12b. KIND OF BUSINESS OR INDUSTRY: -

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. | 13b. COUNTY: Prod. | 13c. CITY OR TOWN: Mt. Rainier | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 13131 Manor Dr. 20711

14. FATHER'S NAME — FIRST: Enoch | MIDDLE: Andrew | LAST: Harlan

15. MOTHER'S MAIDEN NAME — FIRST: SARAH | MIDDLE: - | LAST: Kruit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): - | (IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: -

17. INFORMANT — ADDRESS: Mr. Enoch A. Harlan 13131 Manor Dr. 21771

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. | MONTH | DAY | YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/1, 19 88, to 10/1, 19 88, that (I) (we) last saw the deceased alive on 10/1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Avraham Kadar | DEGREE: MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): AVRAHAM KADAR

22e. ADDRESS: 325 CHARLES St. Rockville Md 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10-4-88

23c. NAME OF CEMETERY OR CREMATORY: Arlington Baptist Cem.

23d. LOCATION — CITY OR TOWN: Randallstown | COUNTY: Balto. | STATE: Md.

24. FUNERAL DIRECTOR — NAME: Bryan W. Clary | ADDRESS: 10 W. Padonia Rd.

25a. DATE REC'D. BY REGISTRAR: OCT 6 1988

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Items 13a-e per birth cert. 11/17/88 DAD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 38273

012355 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby H MIDDLE: AKA Samuel Harlan LAST: HARLAN		2a. DATE OF DEATH MONTH 10 DAY 1 YEAR 88	2b. HOUR 6:30 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH 10 DAY 1 YEAR 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS 2 MIN. 24
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George Hosp. Cent.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Fred.	13c. CITY OR TOWN: Mt Clary	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 13131 Manor Dr 21771			
14. FATHER'S NAME FIRST: Enoch MIDDLE: Andrew LAST: Harlan		15. MOTHER'S MAIDEN NAME FIRST: SARAH MIDDLE: — LAST: Kruit	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): — (IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Mr. Enoch A. Harlan	ADDRESS: 13131 Manor Dr., 21771

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Prematurity	
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/1/88 to 10/1/88, that (I) (we) last saw the deceased alive on 10/1/88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Avraham Kadar	DEGREE: MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/1/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): AVRAHAM KADAR		22e. ADDRESS: 325 CHARLES St. Rockville Md, 20850	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/4/88	23c. NAME OF CEMETERY OR CREMATORY: Arlington Baptist Cem.	23d. LOCATION CITY OR TOWN: Randallstown	COUNTY: Balto. STATE: Md.
24. FUNERAL DIRECTOR: Bryan W. Clary	ADDRESS: Bryan W. Clary, 10 W. Padonia Rd., 21093	25a. DATE REC'D. BY REGISTRAR: OCT 6 1988	25b. REGISTRAR'S SIGNATURE: Lillian Davidson-Landeck	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF M...

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

19891 JAN 20 89

REG. NO. 88 3 3 2 7 9

1. DECEASED NAME (TYPE OR PRINT) FIRST: George	MIDDLE: E (Elmer)	LAST: Hill	2a. DATE OF DEATH MONTH: 12	DAY: 27	YEAR: 88	2b. HOUR: 7 55 A M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: 06 DAY: 05 YEAR: 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.				
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Pineview Extended Care Fac'lty	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Prince Geo	Brandywine	YES ☒ NO ☐	14262 Brandywine Rd. 20613

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
James Edward Hill	Margaret Priscilla Ford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			14000 Tower Road Erma H. Brooks Brandywine, MD. 20613

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): old CVA - Coronary Atherosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/14, 19 88, to 12/27, 19 88, that (I) (we) last saw the deceased alive on 12/24, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]		12/27/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Reza Mostaar	9235 2[illegible] Rd 20746

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/30/'88	Resurrection Cem	Clinton, P.G. Co., MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Martell Adams, Aquasco Md 20608	JAN 6 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH 10-60M 7/84 (VRA 15, 4)

9899 JAN 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 33280

1. DECEASED NAME (TYPE OR PRINT): FIRST John MIDDLE Hall LAST Irons

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH Dec DAY 29 YEAR 19 88 — 2b. HOUR 6:47 AM

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH Nov DAY 20 YEAR 1918 — 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Dec DAY 29 YEAR 19 88 — 2d. HOUR 6:47 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Phila., Pa. — 7b. CITIZEN OF WHAT COUNTRY?: United States — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Laurel — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Fountain Mgr. — 12b. KIND OF BUSINESS OR INDUSTRY: Drug Fair

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Prince Georges — 13c. CITY OR TOWN: Laurel — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 10077 Wash. Blvd #10

14. FATHER'S NAME: FIRST Norman MIDDLE LAST Irons

15. MOTHER'S MAIDEN NAME: FIRST Margaret MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): 1942-1945

16b. SOCIAL SECURITY NO.: 150-09-5898

17. INFORMANT: Lucy M. Irons — ADDRESS: 10071 Washington Blvd. #10 Laurel, Md. 20707

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Carcinoma of Larynx

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Dep't MEDICAL EXAMINER — DATE SIGNED: Dec 29, 1988

EXAMINER'S NAME (TYPE OR PRINT): Dr. John S. Rogers — ADDRESS: 1919 Seminary Rd. Silver Spr. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 12/31/88 — 23c. NAME OF CEMETERY OR CREMATORY: Balto.Wash.Crematory — 23d. LOCATION CITY OR TOWN: Laurel COUNTY: P.G. STATE: Maryland

24. FUNERAL DIRECTOR NAME: Fleck Funeral Home, Inc. — ADDRESS: 7601 Sandy Spring Rd. Laurel, Md. 20707 — 25a. DATE REC'D. BY REGISTRAR: JAN 5 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 250 BR DHMH - 10 (VR A15 ME (9))

020434 JAN 25 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38281

1. DECEASED NAME (TYPE OR PRINT): First: James; Middle: Curtis; Last: Jones

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ — Month/Day/Year: 11-11-1988 — 2b. HOUR: M

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH: Month/Day/Year: 4 9 24 — 6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. — IF UNDER 1 YR.: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN

2c. DATE PRONOUNCED DEAD: 11-11-1988 — 2d. HOUR: 8:57 pm

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: P. G. MD.

10. CITY OR TOWN OF DEATH: Cottage City

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS): 4142 Bunker Hill Road

12a. USUAL OCCUPATION (TYPE OF WORK EOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: COTTAGE CITY — 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ — 13e. STREET ADDRESS: 4142 Bunker Hill Rd. 20722

14. FATHER'S NAME: First / Middle / Last

15. MOTHER'S MAIDEN NAME: First / Middle / Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Juliet Jones-5872 Southern Ave S.E./Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Diabetic ketoacidosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: [illegible]

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 11-11-88

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — 23b. DATE: 11-11-88 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION CITY OR TOWN / COUNTY / STATE

24. FUNERAL DIRECTOR NAME / ADDRESS: State Anatomy Board Balto., Md.

25a. DATE REC'D. BY REGISTRAR: NOV 18 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 33282

19896 JAN 20 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lalloobhai	MIDDLE:	LAST: Mistry	2a. DATE KNOWN OF DEATH / ESTIMATED: Dec 29 19	MONTH / DAY / YEAR	2b. HOUR: 8:00 AM / PM
3. SEX: M	4. RACE: Hindu Indian	5. DATE OF BIRTH MONTH DAY YEAR: June 10 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDE 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD: Dec 29 19	MONTH / DAY	2d. HOUR: 2:12 AM / PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): India	7b. CITIZEN OF WHAT COUNTRY? India	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges		MD.		
10. CITY OR TOWN OF DEATH: Landham	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctors Hosp. of P.G.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Accounting				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Mitchellville	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 4002 Ramsey Dr.			
14. FATHER'S NAME FIRST: Naranji	MIDDLE:	LAST: Mistry	15. MOTHER'S MAIDEN NAME FIRST: Deviben	MIDDLE: N.	LAST: Mistry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): n/a	(IF YES, GIVE WAR OR DATES): n/a	16b. SOCIAL SECURITY NO.: 215-04-7139	17. INFORMANT: Champaklal Mistry	ADDRESS: same as 13e			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf.

Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Myocardial Dis.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): COPD.

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Dept. MEDICAL EXAMINER DATE SIGNED: Dec 29, 1988

EXAMINER'S NAME (TYPE OR PRINT): Dr. John S. Rogers ADDRESS: 1919 Seminary Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 12/31/88	23c. NAME OF CEMETERY OR CREMATORY: Balto.Wash.Crematory	23d. LOCATION CITY OR TOWN: Laurel	COUNTY: P.G. STATE: Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Fleck Funeral Home, Inc. 7601 Sandy Spring rd. Laurel, Md. 20707	25a. DATE REC'D. BY REGISTRAR: JAN 5 '89	25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall		

(VR A15 ME (5))

019892 JAN 20 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2

DHMH - 10.50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38283

1. DECEASED NAME (TYPE OR PRINT): FIRST Thomas (Henson) MIDDLE Pinkney LAST

2a. DATE OF DEATH: MONTH 12 DAY 29 YEAR 88

2b. HOUR 4:30 AM

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH: MONTH 05 DAY 03 YEAR '11

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.

10. CITY OR TOWN OF DEATH: CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer

12b. KIND OF BUSINESS OR INDUSTRY: Farming

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince Geo

13c. CITY OR TOWN: Brandywine

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 18814 Horsehead Road 20613

14. FATHER'S NAME: FIRST Thomas Henson MIDDLE LAST Pinkney, Sr.

15. MOTHER'S MAIDEN NAME: FIRST Mattie MIDDLE LAST Skinner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213 44 6809

17. INFORMANT: Rebecca Brown ADDRESS: SAA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus, Peripeal Vascular disease.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Donald Hayes DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/29/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Oswald Hayes

22e. ADDRESS: 9131 Piscataway Rd

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/3/'88

23c. NAME OF CEMETERY OR CREMATORY: Christ Church

23d. LOCATION: CITY OR TOWN Baden COUNTY P.G. Co., STATE MD

24. FUNERAL DIRECTOR: NAME Martel Adams ADDRESS Aquasco, Md 20608

25a. DATE REC'D. BY REGISTRAR: JAN 6 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

020582 JAN 25 19

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

S 8 3 8 2 8 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Kenneth MIDDLE Earl LAST Provow
Kenneth E Provow

2a. DATE OF DEATH: MONTH 12 DAY 18 YEAR 88
2b. HOUR: 1 Am M

3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH 12 DAY 17 YEAR 33
6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's Co MD.

10. CITY OR TOWN OF DEATH: Clinton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): So. Maryland Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Super. Road Work
12b. KIND OF BUSINESS OR INDUSTRY: Concreate & Paving

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Charles
13c. CITY OR TOWN: Waldorf
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 207 Bell Tree LAne 20601

14. FATHER'S NAME: FIRST Bennie MIDDLE LAST Provow
15. MOTHER'S MAIDEN NAME: FIRST Nina MIDDLE Pearl LAST Thomas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 245-42-2422
17. INFORMANT: Georgia Provow
ADDRESS: Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Advanced Pancreatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b): CARDIORESP FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary embolism & DVT

19a. DATE OF OPERATION: —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/17 19 88 to 12/18 19 88, that (I) (we) last saw the deceased alive on 12/17 19 88; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gary S. Glover
DEGREE: MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED:
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GARY S. GLOVER
22e. ADDRESS: 7501 Surratts Rd #303 Clinton, Md. 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 12/20/88
23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory
23d. LOCATION: CITY OR TOWN Clinton, COUNTY Prince George's, STATE Md

24. FUNERAL DIRECTOR NAME, ADDRESS: Lee Funeral Home, Inc, 6683 Old ALexander Ferry Rd Clinton, Md 20735
25a. DATE REC'D. BY REGISTRAR: DEC 22 1988
25b. REGISTRAR'S SIGNATURE: Gene Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

IMPORTANT:

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 38285

0188822 JAN 20 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEA EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTO PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	CLAIRE LOUGHREY SHUNK			2a. DATE KNOWN OF DEATH ☑ / ESTIMATED ☐ MONTH DAY YEAR	12-30 1988	2b. HOUR M
3. SEX	Female	4. RACE	Cau	5. DATE OF BIRTH MONTH DAY YEAR	Aug 8, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.
IF UNDER 1 YR. MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	12-30 1988	2d. HOUR 1743 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Wash, D.C.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. George MD
10. CITY OR TOWN OF DEATH	Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	So. Md. Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Secretery	12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Pr. George	13c. CITY OR TOWN	Temple Hills	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS	6211 Hope Drive					20748
14. FATHER'S NAME FIRST / MIDDLE / LAST	William F. Loughrey			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Margaret Murphy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	577-20-9784	17. INFORMANT James Shunk ADDRESS 6211 Hope Drive Temple Hills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Carcinoma of the tongue	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-30-88

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	Jan 3, 1989	Arlington Nat'l	Arlington	Va
24. FUNERAL DIRECTOR NAME	Huntt Funeral Home	ADDRESS P.O. Box 156 Waldorf, Md. 20604	25a. DATE REC'D. BY REGISTRAR JAN 10 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson Rondeau

(VR A15 ME (5))

1144 DEC 27 '88 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF RE 38236

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Andre	Ricardo	Smith	12-4		1988	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	Black	August 14,1970	18 YRS.			12-4 1988	2:50 a.M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.	United States		Prince George's County, MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Marlow Heights	3126 Branch Avenue	Unemployed	None				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS			
District of	Columbia	Washington		3110 Pennsylvania Avenue, S.E. (20020)			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST		
Gilbert	Ronald	Smith	Joyce	Elizabeth	Hewlett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS				
No		577-82-1941	3110 Pennsylvania Ave.SE;Wash.D.C. Gilbert R.& Joyce H. Smith(parents)20020				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Multiple Gunshot Wounds

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 1:05 XX 12-4 1988	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject was shot
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): skating rink	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 3126 Branch Avenue, Prince George's Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐,

ACTUAL SIGNATURE John E. Smialek M.D. TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 12-4-88

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec.07,1988	Washington National Cem.	Suitland,P.G.Co.,Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LATNEY'S FUNERAL SERVICE, INC. 3831 Georgia Avenue,N.W.;Washington,D.C.20011	DEC 23 1988	Julia Davidson-Randall

BP

(VR A15 ME (5))

020209 JAN 5 28

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 338287

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Allie	Middle: Mae	Last: Taylor	2a. DATE OF DEATH Month: 12 Day: 28 Year: 88
2b. HOUR: 9:40 M			
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month Day Year: January 19, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.
If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Real Estate Agent	12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Prince Georges	Clinton	YES ☒ NO ☐	9106 Pine View Lane 20735

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Paul Jenkins	Mabel Worthy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		153-14-9670	Marjorie Dixon-grd-daughter-	801 Booker Drive Seat Pleasant

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Vascular Accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 12/28/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Oswald Haye	MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/28/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Oswald L Haye	9131 Piscataway Rd Clinton Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	December 31, 1988	Lincoln Memorial Cemetery	Landover, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Stewart Funeral Home	4001 Benning Road, N.E.	JAN 3 '89	Julia Davidson-Mendez

DHMH - 16 50M 1/81 (VRA 15, 4)

Item #'s 18a21a,b,c,d,e,f,22a per med
For Film G648 cg 2/10/89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88 3 3 2 3 3

021001 JAN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 2. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 3 AND 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN ☐ OF ESTIMATED ☒ DEATH	MONTH 12	DAY 30	YEAR 19 88	2b. HOUR M
Bryant		Taylor					
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH: October 14, 1959	6. AGE (IN YEARS LAST BIRTHDAY): 29 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD: 12 31 19 88	2d. HOUR 10:20 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: Capitol Heights	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1204 Kayak Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sanitation Employee	12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Georges	Capitol Hgts	YES XX NO ☐	1204 Kayak Avenue

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Earl Taylor	Carolyn Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	578-88-9885	Carolyn Taylor Mother 4224 9thST.S.E. WashingtonDC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute narcotic and alcohol intoxication	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	12/31/89 19	Unknown

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	1204 Kayak Ave. Capitol Hgts. Prince Geo. Co. Md.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒,

ACTUAL SIGNATURE Chas P. Kokes M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 1/1/89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	07 Jan 89	Harmony MEM. Park	Landover, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Frazier's Funeral Home 389 R.I. Ave.N.W. Wash., D.C.	JAN 27 1989	Jacqueline Davidson-Hendricks

07/84 25M BP 316

DHMH - 17 (VR A15 ME (5))

019895 JAN 20 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33289
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

"HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Minnie — MIDDLE: — LAST: Thompson			2a. DATE OF DEATH — MONTH: December — DAY: 29 — YEAR: 88	2b. HOUR: 11 40 AM
3. SEX: Female	4. RACE: C	5. DATE OF BIRTH — MONTH: FEB RUARY — DAY: 28 — YEAR: 11	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Magnolia Gardens Nursing Home, Hotel Housekeeper House Keeping		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Clinton	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: #1108 8600 Mike Sharpire Dr. 20735
14. FATHER'S NAME — FIRST: Robert — MIDDLE: Littleton — LAST: McElwee			15. MOTHER'S MAIDEN NAME — FIRST: Gertie — MIDDLE: Ann — LAST: McCullough	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 229-03-1785A	17. INFORMANT: Catherine Quimby	ADDRESS: 8600 MIKE SHAPIRE DR. CLINTON, MD. 20735

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): NATURAL CAUSES — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Many years
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SENILE DEMENTIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/23, 19 88, to 12/29, 19 88, that (I) (we) last saw the deceased alive on 12/, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): P SCHISSLER MD — 22e. ADDRESS: 7500 Greenway Ctr Pl Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Jan 3 1989	23c. NAME OF CEMETERY OR CREMATORY: Washington National	23d. LOCATION — CITY OR TOWN: Suitland — COUNTY: P.G. — STATE: MD	
24. FUNERAL DIRECTOR — NAME: Robert E. Wilhelm Funeral Home — ADDRESS: Suitland MD	25a. DATE REC'D. BY REGISTRAR: JAN 5 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 10

DHMH 4-6 00M 7/84
(VRA 15, 4)

019867 JAN 20 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 8 3 3 2 9 0

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner Notified - Released to PMD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Bae	K.	YU	December 28, 1988	4:32P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Korean	Oct. 25, 1915	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Korea	Korea		Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors Of Lanham	Self-employed	Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. Geo.	Lanham	YES ☒ NO ☐	9716 Luria Lane 20706

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Duk Jun Yu	Unk. Lee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		218-96-6846	Paul Yu same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory fadure

DUE TO, OR AS A CONSEQUENCE OF (b) Severe emphysema

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertension.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug. 18 19 87 to Dec. 27 19 88 that (I) (we) last saw the deceased alive on Dec. 27 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Yk Yoon M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/28/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Year-Kwon Yoon M.D.	7307 Baltimore Ave., College Pk., Md. 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/30/88	Gate Of Heaven Cem.	Silver Spring, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rendon/Hale Lanham Fun'l Home 9013 Annapolis Rd. Lanham, Maryland 20706	JAN 4 '89	Julia Davidson-Randall

DHMH 16 (OM 1/88) (VRA 15-4)

20737 JAN 26 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33291
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: William	MIDDLE: Gaither	LAST: BRYANT	2a. DATE OF DEATH MONTH DAY YEAR: December 29, 1988	2b. HOUR: 1:21 AM		
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 2 - 6 - 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne	MD.		
10. CITY OR TOWN OF DEATH: Centreville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian - Corsica Hills	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home Builder	12b. KIND OF BUSINESS OR INDUSTRY: Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: A.A.	13c. CITY OR TOWN: Annapolis	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 233 Old Mill Bottom Road	21401	
14. FATHER'S NAME FIRST: Augustus	MIDDLE	LAST: BRYANT	15. MOTHER'S MAIDEN NAME FIRST: Frances	MIDDLE	LAST: Barry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 216-32-1970	17. INFORMANT: Peggy Bryant	ADDRESS: 233 Old Mill Bottom Road Annapolis, Md. 21401		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASCVD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yr
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 5-29, 1984, to Dec 29, 1988, that (I) (we) last saw the deceased alive on Dec. 27, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. R. Smith Jr. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/30/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. R. Smith Jr. — 22e. ADDRESS: Centreville Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/31/88	23c. NAME OF CEMETERY OR CREMATORY: St. Margaret's Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Annapolis A.A. MD.	
24. FUNERAL DIRECTOR NAME / ADDRESS: Taylor Funeral Chapel, Annapolis, MD.	25a. DATE REC'D BY REGISTRAR: JAN 09 1989	25b. REGISTRAR'S SIGNATURE: Julia Taubman-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

020155 JAN 2 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 33292

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR	2b. HOUR
James		Johnson	12-31-88	12:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
male	Negro	11 4 37	51 YRS.			1-2-89	1:20 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Somerset

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Princess Anne	Rt.2 Box 513 D Princess Anne	Laborer	Labor

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
Maryland	Somerset	Princess Anne		Rt. 2 Box 513 D

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Archie		Doane	Dorothy	Whitney	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212036011 96	Walter Opher	Baltimore, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CVA	Unknown
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Laura A. Sterling M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1-3-89

EXAMINER'S NAME (TYPE OR PRINT) James A. Sterling, M.D. ADDRESS 320 West Main Street Crisfield MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1-7-89	Greenwood Cemetery	Princess Anne Som. MD

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arrthony E. Ward	Crisfield, MD 21817	JAN 04 '89	Julia Davidson-Randell

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP 2

DHMH - 17
(VR A15 ME (5))
15M 7/77

021081 JAN 3 0 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 33293

1. DECEASED NAME (TYPE OR PRINT): FIRST Howard; MIDDLE Eugene; LAST Copper

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH 12 DAY 26 YEAR 1988 — 2b. HOUR unkn

3. SEX: Male — 4. RACE: Blk — 5. DATE OF BIRTH: MONTH 02 DAY 06 YEAR 25 — 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 6 YEAR 1989 — 2d. HOUR 1130 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot 20 MD.

10. CITY OR TOWN OF DEATH: Easton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): RFD Box ? (Home) — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD — 13b. COUNTY: Talbot — 13c. CITY OR TOWN: Easton — 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ — 13e. STREET ADDRESS: RFD Box ? 21601

14. FATHER'S NAME: FIRST Clifford; MIDDLE; LAST Flamer

15. MOTHER'S MAIDEN NAME: FIRST Agnes; MIDDLE; LAST Copper

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — 16b. IF YES, GIVE WAR OR DATES: — 16b. SOCIAL SECURITY NO.

17. INFORMANT: Agnes — ADDRESS: Copper

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atherosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: mintues
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 1/6/89

EXAMINER'S NAME (TYPE OR PRINT) Ludwig J. Eglseder, III, M.D. — ADDRESS Rt.3, Box 106 Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE 1/11/89 — 23c. NAME OF CEMETERY OR CREMATORY: Coppersville Cem — 23d. LOCATION CITY OR TOWN: Easton — COUNTY: TA — STATE: MD

24. FUNERAL DIRECTOR NAME: [signature] — ADDRESS: 319 E. Dover St Easton MD

25a. DATE REC'D. BY REGISTRAR: JAN 18 '89 — 25b. REGISTRAR'S SIGNATURE: Jacha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 3

DHMH - 17
(VR A15 ME (5))

020050 JAN 2 3 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 3329 1 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Warren	W.	Edwards, Sr.	December 30, 1988	6:53 A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	10 22 25	63 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
PA	U.S.A.		Talbot MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Easton	Route 50		truck driver	town gov't	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	Easton	YES ☐ NO ☒	Route 50 21601

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Oscar	G.	Edwards Sr	Mary	E.	Clawson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		114-14-8107	Brenda S Murphy	P O Box 1611 Easton MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG CANCER, SMALL CELL — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 MO
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-8, 19 88, to 12-30, 19 88, that (I) (we) last saw the deceased alive on 10-17, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Stephen P Carney MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1-3-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stephen P. Carney, M.D.	Rt 3 Box 106 Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/4/89	Spring Hill Cemetery	Easton Talbot MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home Easton, Maryland	JAN 03 '89	Julia Davidson-Randall

20026 JAN 23 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38295
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and sent to the State Registrar with the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	OLIVE BELLE JONES			2a. DATE OF DEATH — MONTH / DAY / YEAR	DEC. 30, 1988
				2b. HOUR	8:30A.M.
3. SEX	FEMALE	4. RACE	CAUC.	5. DATE OF BIRTH — MONTH / DAY / YEAR	JULY 28, 1892
6. AGE (IN YEARS LAST BIRTHDAY)	96 YRS.	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS. — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	TALBOT MD.				
10. CITY OR TOWN OF DEATH	EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	WILLIAM HILL HEALTH CARE CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HOUSEWIFE
				12b. KIND OF BUSINESS OR INDUSTRY	HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	TALBOT	13c. CITY OR TOWN	WITTMAN
13d. INSIDE CITY LIMITS?	YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE	UNKNOWN 21676		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	SILAS LOMAX	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	IDA SEYMOUR		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	-------	16b. SOCIAL SECURITY NO.	220-01-5982A
17. INFORMANT — ADDRESS	RAY JONES WITTMAN, Md. 21676				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) [~~the hospital~~] attended the deceased from 7-25 19 88 to 30 Dec 19 88 that (I) [~~we~~] last saw the deceased alive on 29 Dec 19 88 and that in (my) [~~our~~] opinion death occurred on the date and hour and from the causes stated above. (I) [~~we~~] did [~~not~~] view the body after death.

22b. SIGNATURE	R. Lane Wroth, MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 12-30-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	R. LANE WROTH M.D.	22e. ADDRESS	ST. MICHAELS, MARYLAND 21663

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	JAN. 3, 1989
23c. NAME OF CEMETERY OR CREMATORY	OLIVET CEMETERY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE	ST. MICHAELS, TALBOT Md.
24. FUNERAL DIRECTOR — NAME / ADDRESS	Harrison E. Leonard St. Michaels, Md.	25a. DATE REC'D. BY REGISTRAR	JAN 03 '89
25b. REGISTRAR'S SIGNATURE	Julia Davidson Randall		

BP 4

DHMH - 16 60M 7/84
(VRA 15, 4)

018759 JAN 11 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 338296
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: G.	MIDDLE: Frank	LAST: MORRIS	2a. DATE OF DEATH MONTH DAY YEAR: 12 24 88	2b. HOUR: 805 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 29 06	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): EASTON MEM. HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): mechanic	12b. KIND OF BUSINESS OR INDUSTRY: automotive		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	Easton	YES [ ] NO [X]	Matthewstown Road 21601

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Fred / Morris Sr	Marilda / Wroten

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		218-12-1568	Eloise P Morris	P O Box 175 McDaniel MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(IMMEDIATE CAUSE (a))	respiratory failure	
DUE TO, OR AS A CONSEQUENCE OF (b)	congestive heart failure	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	arteriosclerotic cardiovascular disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): acute + chronic renal insufficiency

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
—	—		

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	—	—

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/24 19 88 to 12/24 19 88, that (I) (we) last saw the deceased alive on 12/24 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Albert T. Dawkins	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/24/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ALBERT T. DAWKINS JR	588 IDLEWILD AV. EASTON MARYLAND 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/28/88	Woodlawn Memorial	Easton / Talbot / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home Easton, Md.	DEC 29 '88	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 338297

01876 | JAN 11 89

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE Agnes LAST Potter
2a. DATE OF DEATH: MONTH 12 DAY 5 YEAR 88
2b. HOUR: M
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: MONTH 11 DAY 25 YEAR 1904
6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY? U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): H One
12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Laborer
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md. 13b. COUNTY: Talbot 13c. CITY OR TOWN: Easton 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE: Hammond St. 21601

14. FATHER'S NAME: FIRST Howard MIDDLE H LAST Hurst
15. MOTHER'S MAIDEN NAME: FIRST Henrietta MIDDLE H LAST Hurst
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-30-3246
17. INFORMANT: Mildred Potter ADDRESS: 121 S Lacust Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ovarian Cancer
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 02/20 19 85 to 12/12 19 88, that (I) (we) last saw the deceased alive on 11/22 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE:
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED:
22d. PHYSICIAN'S NAME (TYPE OR PRINT): L. Thomas Divilio, M.D.
22e. ADDRESS: 404 Marvel Ct Easton Md 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-12-88
23c. NAME OF CEMETERY OR CREMATORY: Richardson
23d. LOCATION CITY OR TOWN: Easton COUNTY: Talbot STATE: Md.
24. FUNERAL DIRECTOR NAME: Bennie Smith ADDRESS: P. O. Box 528 Hurlock, Md
25a. DATE REC'D. BY REGISTRAR: DEC 28 '88
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the burial director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to removal.

BP 6

DHMH - 16 50M 4/83
(VRA 15, 4)

018757 JAN 1 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38293
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
BARBARA	LOUISE	SALOMON	DEC. 27, 1988	8:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN.
FEMALE	CAUCASIAN	October 4 1912	76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. BALTIMORE CITY OR COUNTY OF DEATH		
NEW JERSEY	U.S.		TALBOT MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
EASTON	MERIDIAN NURSING CENTER	HOUSEWIFE			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	TALBOT	OXFORD	YES ☑ NO ☐	200 BANK ST./ 21654

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LANCELOT		ELY	ALICE	TRIMMER	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		090-01-5178	WILLIAM L. SALOMON	P O Box 99 OXFORD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 08-19-88

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive and arteriosclerotic uncertain

DUE TO, OR AS A CONSEQUENCE OF (c) cardiovascular disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): none

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) this hospital) attended the deceased from 9-25, 1973, to 12-27, 1988, that (I) we) last saw the deceased alive on 12-27 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we) did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert W. Trever, M.D.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-27-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ROBERT W. TREVER, M.D.	RD3 Box 297 ROUTE 50 EASTON, MD. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	12-28-88	SALISBURY CREM.	SALISBURY,	WICOMICO,	MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
NEWNAM FUNERAL HOME	EASTON, MD.	DEC 29 '88	Julia Davidson-Randall

BP

BHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

023322 FEB 21 89

1- FOR STATE REGISTRAR

REG. NO. 3329 7

1. DECEASED NAME (TYPE OR PRINT): FIRST Baby; MIDDLE Girl; LAST Clopper

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 5 YEAR 19 88

2b. HOUR

3. SEX: female

4. RACE: White

5. DATE OF BIRTH: MONTH 10 DAY 5 YEAR 88

6. AGE (IN YEARS LAST BIRTHDAY): YRS.; IF UNDER 1 YR. MONTHS; DAYS; IF UNDER 24 HRS. HOURS; MIN.

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 8 YEAR 19 88

2d. HOUR 6:30P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County 21 MD

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 671 Highland Way

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: WashingtonCo

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 671 Highland Way 21740

14. FATHER'S NAME: FIRST Joe; MIDDLE; LAST Rockwell

15. MOTHER'S MAIDEN NAME: FIRST O'Dell; MIDDLE Clopper,; LAST 671Highland Way,

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): n/a

(IF YES, GIVE WAR OR DATES): n/a

16b. SOCIAL SECURITY NO.: n/a

17. INFORMANT: O'dell Clopper ADDRESS: Hagerstwon, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Perinatal death

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): umbilical cord around neck

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described obave, held an Autopsy [XX] Inspection [ ], Inquiry [ ], and in my opinion death resulted from Natural causes [XXX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Margarita Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 10/9/88

EXAMINER'S NAME (TYPE OR PRINT): Margarita Korell, M.D. ADDRESS: 111Penn Street, Balto. MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation

23b. DATE: 10/12/88

23c. NAME OF CEMETERY OR CREMATORY: Rest HAVEN Cemetery

23d. LOCATION CITY OR TOWN; COUNTY; STATE: Hagerstown, Wash Co, Maryland

24. FUNERAL DIRECTOR NAME; ADDRESS: MINNICH FUNERAL HOME, HAGERSTOWN, MD 21740

25a. DATE REC'D. BY REGISTRAR: JAN 20 1989

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

020939 JAN 20 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38300
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Bertha	Virginia J.	ELKIN	December	27,	1988 / 5:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	Dec. 17, 1900	88 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Washington County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Williamsport	Homewood Retirement Center	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Washington	Williamsport	YES ☒ NO ☐	2750 Virginia Avenue 21795

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
James A. Jones	Clara M. Crum

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	189-24-2251	Mrs. Frances Ramsburg, P. O. Box 49 Harpers Ferry, W. Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	MYOCARDIAL INFARCTION, ACUTE	
DUE TO, OR AS A CONSEQUENCE OF (c)	HYPERTENSIVE CARDIOVASCULAR DISEASE	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ATRIAL FIBRILLATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug 88, 19 86, to Dec 88, 19 88, that (I) (we) last saw the deceased alive on Dec 6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
For A.W. Ditto, MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/28/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stephen Metzner For A.W. Ditto, MD	1825 Howell Rd. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec 31, 1988	Mt. Olivet Cemetery	Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Richard C.E. Basford Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	DEC 28 1988	Julia Davidson-Randall

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

020935 JAN 20 89

88 38301 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
John	E.	Holland	December 28, 1988	6:05 Am

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	Black	May 22, 1924	64 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		Washington MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Western Maryland Center	CONSTRUCTION	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	FREDERICK	FREDERICK	YES X NO	26 Ice Street, Frederick, MD 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
IRVIN	PERCIL	HOLLAND	CATHERINE	VIRGINIA	LEE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	217-12-2959	William Carroll, Sr., 17 Orndorff Dr.	Brunswick, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia, bilateral	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebrovascular accident	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Sacral decubitus ulcer; Chronic pancreatitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES / NO X	YES / NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from Nov. 10, 19 88, to Dec. 28, 19 88, that (I) (~~was~~ last saw the deceased alive on Dec. 28, 19 88, and that in (my) (~~his~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~ did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Fe U. Porciuncula	M.D. ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	Dec. 28, 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Fe U. Porciuncula, M. D.	1500 Pennsylvania Ave., Hagerstown, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/30/88	HOPEHILL CEMETERY	FREDERICK / FREDERICK / MD 21740

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER	1621 Opossumtown Pike, Frederick, MD 21701	DEC 29 1988	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by him.

DHMH - 1050M 1/81 (VRA 15, 4)

020948 JAN 30 88

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38302

1. DECEASED NAME (TYPE OR PRINT): Margaret (FIRST) Elizabeth (MIDDLE) KEENEY (LAST)

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Dec. 18 1988 (MONTH DAY YEAR) — 2b. HOUR 3:45 P M

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: Sept. 28, 1927 (MONTH DAY YEAR) — 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: Dec. 18 1988 (MONTH DAY YEAR) — 2d. HOUR 4:46 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD

10. CITY OR TOWN OF DEATH: Hagerstown — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY: Home

13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Frederick — 13c. CITY OR TOWN: Walkersville — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 8804 Utopia Place 21793

14. FATHER'S NAME: Louis (FIRST) (MIDDLE) Cole, Sr. (LAST)

15. MOTHER'S MAIDEN NAME: Elsie (FIRST) (MIDDLE) Crummitt (LAST)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): None

16b. SOCIAL SECURITY NO.: 212-74-0478

17. INFORMANT: Miss Wanda Keeney — ADDRESS: 61 West Franklin St., Hagerstown, Md. 21740

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): #038 - Sepsis due to large left vulvar-inguinal abscess — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 weeks
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Edward W Ditto — M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: Dec. 19, 1988

EXAMINER'S NAME (TYPE OR PRINT): Edward W. Ditto, III, M.D. — ADDRESS: 217 West Washington Street Hagerstown, Maryland 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12-22-1988 — 23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery — 23d. LOCATION CITY OR TOWN COUNTY STATE: Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME: Keeney & Basford P.A. Funeral Home — ADDRESS: 106 East Church St., Frederick, Md. 21701 — 25a. DATE REC'D. BY REGISTRAR: DEC 22 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84 25M

DHMH - 17
(VR A15 ME (5))

020170 JAN 23 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88 3303

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES	MIDDLE: V	LAST: MANNING	2a. DATE OF DEATH MONTH DAY YEAR: DECEMber 27, 1988	2b. HOUR: 750 PM	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: Nov 19 1922	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TN.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WASHINGTON MD.		
10. CITY OR TOWN OF DEATH: HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WESTERN MARYLAND CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ROAD CREW	12b. KIND OF BUSINESS OR INDUSTRY: Ho. Co. Rd. Dep.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	HOWARD	Ellicott City	YES ☒ NO ☐	3766 St. Paul St. 21043

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William		Manning	Mattie		Gibson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	217-30-2854	CHARLOTTE BURRIS	3766 St Paul St. Ellicott City, MD 21043

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE OBSTRUCTIVE PULMONARY DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Week

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that ☒ (this hospital) attended the deceased from Nov 3 19 88, to Dec 27 19 88, that (I ~~XX~~) last saw the deceased alive on Dec 27 19 88, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) (did) (~~XX~~ not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
F. U. Porciuncula	M.D.	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☑	Dec 27 1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
F. U. Porciuncula	1500 Pennsylvania Ave Hagerstown Md 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-30-88	True Gospel	Lisbon / Howard / Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SLACK F.H. P.O. Box 208 Ellicott City MD. 21043	DEC 29 88	

020587 JAN 25 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33304 REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: Myrtle	MIDDLE: BERNICE	LAST: ANDERSON	2a. DATE OF DEATH MONTH DAY YEAR: 12 22 88	2b. HOUR: 1513 P M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 6 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO 22 MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: —		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WICOMICO	PARSONSBURG	YES ☐ NO ☒	OLD OCEAN CITY RD. 21849

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
UNKNOWN			BEATRICE	ADDIE	ADAMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-18-4759	CORDELLIA J. BOZMAN	OLD OCEAN CITY ROAD PARSONS BURG. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): —

DUE TO, OR AS A CONSEQUENCE OF

(c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
J A Cockey m.d.		12/22/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J A Cockey, m.d.	100 Pagen St Salisbury, Md 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	DEC. 23, 1988	SALISBURY CREMATORY	SALISBURY WIC MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ZELLER FUNERAL HOME SALISBURY MD.	JAN 10 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 1

DHMH - 1650M 1/81 (VRA 15, 4)

020589 JAN 25 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 33305 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

If item 21 is marked as shown, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	MAE / F. / BIRCKETT	2a. DATE OF DEATH — MONTH DAY YEAR	12-31-88
		2b. HOUR	10:30P M
3. SEX	Female	4. RACE	Black
5. DATE OF BIRTH — MONTH DAY YEAR	6 10 1894	6. AGE (IN YEARS LAST BIRTHDAY)	94 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico MD
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Salisbury Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Laborer	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Wicomico
13c. CITY OR TOWN	Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	Zion Road 21801		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	John / / Garrison	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Laura / / Garrison
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	215-763-6899	17. INFORMANT	John Clark
ADDRESS	1212 N. 24 St. Phila, Pa 19121		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatic cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/27, 19 88, to 12/30, 19 88, that (I) (we) last saw the deceased alive on 12/30/88, 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 1/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Dr. William Robins
22e. ADDRESS	US 50 - Civic Ave., Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY / STATE
Burial	12-4-1989	Spring Hill	Hebron	Wicomico, Md.
24. FUNERAL DIRECTOR NAME	Gladys B. Stewart West	ADDRESS	Rd. Olivia St. SALISBURY MD 21801	
25a. DATE REC'D BY REGISTRAR	JAN 10 '89	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall	

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

020085 JAN 2 '89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38306 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JOHN	J	CARRICO	12 -- 30-1988	10:45 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
MALE	WHITE	Dec. 16, 1897	91 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
VIRGINIA	USA		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	SALISBURY NURSING HOME	Accountant	Accounting

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES [X] NO [ ]	1514 Riverside Dr., 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JEFFREY	C.	CARRICO	ALICE	--	BARTLETT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-10-7304	Lola W. Carrico	1514 Riverside Drive Salisbury, MD 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) COPD
DUE TO, OR AS A CONSEQUENCE OF (c) Hypoxia Severe
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 12 26, 19 88, to Dec 30 19 88, that (I) (we) last saw the deceased alive on 12 29, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED 1/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Robins, MD

22e. ADDRESS US 50-Civic Ave., Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	01-03-89	Wicomico Memorial	Salisbury	WI	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral HOme	501 Snow Hill Rd. Salisbury, MD	JAN 5 '89	Julia Davidson-Randall

019739 JAN 19 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38307 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Louise Comegys				2a. DATE OF DEATH MONTH DAY YEAR: December 26, 1988	2b. HOUR: 955 M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 8, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABOR	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Kent	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: CANNON ST 21620	
14. FATHER'S NAME FIRST / MIDDLE / LAST: SAMUEL SISCO		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: ANNA COTTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	16b. IF YES, GIVE WAR OR DATES: —	16b. SOCIAL SECURITY NO.: 220-52-8612	17. INFORMANT: MRS. ISABEL STRONG CANNON	ADDRESS: 5 Strong St.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma pancreas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Multiple decubitus ulcers

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/6, 19 88, to 12/26, 19 88, that I (we) last saw the deceased alive on 12/26, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: V. Hofreuter	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 12/26/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. Hofreuter, M.D.		22e. ADDRESS: Deer's Head Center, Salisbury, Md. 21801	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 12-31-88	23c. NAME OF CEMETERY OR CREMATORY: JAMES CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Chestertown Kent Md.
24. FUNERAL DIRECTOR NAME: Kenneth Wolfe	ADDRESS: Chestertown	25a. DATE REC'D. BY REGISTRAR: JAN 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

R BP 2

DHMH - 16.50M 1/81 (VRA 15, 4)

020733 JAN 2 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88 38308

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Phillips; Middle: ; Last: Jones			2a. DATE OF DEATH Month: 12; Day: 25; Year: 88	2b. HOUR 9 45 AM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH Month: 1; Day: 17; Year: 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deers Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Cambridge	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 533 Cedar ST 21613	
14. FATHER'S NAME First: William; Middle: ; Last: Jones			15. MOTHER'S MAIDEN NAME First: Annie; Middle: ; Last: Stanley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-18-6841	17. INFORMANT: Clara Jones	ADDRESS: 533 Cedar ST. Cambridge MD 21613	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE) (a): Cardiac Arrythmia

DUE TO, OR AS A CONSEQUENCE OF (b): pulmonary edema

DUE TO, OR AS A CONSEQUENCE OF (c): Congestive Cardiomyopathy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): valvular Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/23 19 88 to 12/25 19 88, that (I) (we) last saw the deceased alive on 12/25 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Constantine J Tan DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED: 12/25/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CONSTANTINE J TAN 22e. ADDRESS: 547-D Riverside Dr. Salisbury MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/30/88	23c. NAME OF CEMETERY OR CREMATORY: Smithville Cem	23d. LOCATION CITY OR TOWN: Smithville / COUNTY: Dorchester / STATE: Md.	
24. FUNERAL DIRECTOR NAME: Stewart Funeral Home	ADDRESS: Cambridge Md.	25a. DATE REC'D BY REGISTRAR: JAN - 6 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH 16 50M 1/81 (VRA 15, 4)

020296 JAN 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38309 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ELIZABETH / JEAN / KETELSLEGER	2a. DATE OF DEATH MONTH DAY YEAR	12 23 88	2b. HOUR 6 10P M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR: 05 30 29
6. AGE (IN YEARS LAST BIRTHDAY)	59 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	South Dakota	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO MD.			
10. CITY OR TOWN OF DEATH	SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	DEER'S HEAD CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper / 12b. KIND OF BUSINESS OR INDUSTRY Welding Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Wicomico	13c. CITY OR TOWN: Salisbury / 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ / 13e. STREET ADDRESS: Zion Road/21801
14. FATHER'S NAME FIRST / MIDDLE / LAST	Mark / Charles / Rafferty	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Evelyn / Ryan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	–	16b. SOCIAL SECURITY NO. 468-34-4648
17. INFORMANT	Ann E. Waggoner, 109 Leslie Avenue, Baltimore, MD			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC CARCINOMA — Approximate interval between onset and death: 1983

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA - BREAST — 1981

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Virginia D. Hofleuter	DEGREE M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED 12/23/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRGINIA D. HOFLEUTER	22e. ADDRESS DEER'S HEAD CENTER		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-27-88	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION CITY OR TOWN Salisbury, COUNTY Wicomico, STATE Maryland
24. FUNERAL DIRECTOR NAME, ADDRESS Zeller Funeral Home, Salisbury, Maryland	25a. DATE REC'D. BY REGISTRAR JAN 6 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

R BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

020585 JAN 25 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 8 3 1 0

1. DECEASED NAME (TYPE OR PRINT) FIRST: Doris	MIDDLE: Mildred	LAST: Lewis	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH: 12	DAY: 18	YEAR: 88	2b. HOUR: 0926 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 02 DAY: 05 YEAR: 20	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH: 12 DAY: 18 YEAR: 88	2d. HOUR: 0926 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD				
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	213 Tilghman Road/21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Gray		Jones	Bertha		Sockal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-	222-07-3400	Shirley A. Smith, Rt.3, Box 380 Salisbury, Md. 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John T. Bulkeley M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12-18-88

EXAMINER'S NAME (TYPE OR PRINT): John T. Bulkeley, M.D. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-21-88	Pittsville Cemetery	Pittsville, Wicomico, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Zeller Funeral Home, Salisbury, Md.	JAN 10 '89	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 4. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 3

DHMH - 17 (VR A15 ME (5))

020295 JAN 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38311

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
	John	Charles	Reisinger	December	28,		1988	8:10P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
		MONTH DAY YEAR		MONTHS	DAYS	HOURS	MIN.
Male	White	October 24, 1922	66 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Wicomico County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	West Zion Road	Instructor	U. S. Army

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Wicomico	Salisbury	YES [ ] NO [X]	W. Zion Road/21801

14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST
	Anton		Reisinger		Barbara		Eckhart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1946-1966	069-14-8606A	Maria Reisinger, Salisbury, MD 21801	Rt. 11, Box 756

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Squamous cell carcinoma lung

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

COPD, diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
[ ]		

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) this hospital) attended the deceased from 11/14, 19 88 to 12/28, 19 88, that (I) (we) last saw the deceased alive on 12/20, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED
Charles B Silvia	MD	[X]	[ ]	[ ]	1/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Charles B. Silvia, Jr.	540 Riverside Drive, Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	12-31-88	Springhill Memory Gardens,	Hebron,	Wicomico,	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Zeller Funeral Home,	Salisbury, Maryland	JAN 6 '89	Julia Davidson-Randall

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

020482 JAN 25 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38312 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Jodie	MIDDLE: L	LAST: Robbins	2a. DATE OF DEATH — MONTH: 10	DAY: 13	YEAR: 88
2b. HOUR: 2359 M					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH — MONTH: 5	DAY: 7	YEAR: 71	6. AGE (IN YEARS LAST BIRTHDAY): 17 YRS.
IF UNDER 1 YEAR — MONTHS:	DAYS:	IF UNDER 24 HRS — HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General PGH	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) — 13a. STATE: MD	13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 501 Cedar Street 2485	
14. FATHER'S NAME — FIRST: Edward	MIDDLE: L.	LAST: Robbins Sr.	15. MOTHER'S MAIDEN NAME — FIRST: Joyce	MIDDLE: A.	LAST: Martin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-90-2434	17. INFORMANT: Edward Robbins	ADDRESS: 501 Cedar St. Pocomoke, MD 21851	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): metastatic Rhabdomyosarcoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 10/13, 19 88, that (I) (~~saw~~) last saw the deceased alive on 10/13 19 88, and that in (my) (~~the~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: JG Grasso	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/13/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph A. Grasso	22e. ADDRESS: 145 E. Carroll St Salisbury MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/16/88	23c. NAME OF CEMETERY OR CREMATORY: First Baptist Cem.	23d. LOCATION — CITY OR TOWN: Pocomoke	COUNTY: Worcester STATE: Md
24. FUNERAL DIRECTOR: Watson-Melson Funeral Home	ADDRESS: PO BOX 64 Pocomoke, Md. 21851	25a. DATE REC'D BY REGISTRAR: JAN 24 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

020086 JAN 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 38313
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
MAXWELL	LEE	ROBERTSON, SR.	12	30	88	11:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	WHITE	May 13, 1921	67 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		Wicomico MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Service Tech.	Appliance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Wicomico	Salisbury	YES X NO ☐	1419 Cedar Way, 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Newman	--	Robertson	Edna	--	Nichols

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	ARMY	219-05-3188	Doris Mae Robertson	1949 Cedar Way Salisbury, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO - RESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMED

DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA — 24 HRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CORONARY DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/15, 19 88, to 12/30, 19 88, that (I) (we) last saw the deceased alive on 12/30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 12/31/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	01-03-89	Parsons Cemetery	Salisbury WI MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home, PA	501 Snow Hill Rd. Salisbury, MD	JAN 5 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84 (VRA 15, 4)

MAY 5 '83

020088 JAN 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

88 38314
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: Stanley LAST: Togus	2a. DATE OF DEATH MONTH DAY YEAR: 12 31 88	2b. HOUR: 4:25 PM	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 9 13 21	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Disable	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Wicomico	Salisbury	YES ☒ NO ☐	804 Delaware Ave 21801

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Maurice / / Biship	Hazel / BIVENS / West	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		218 16 8805	Hazel West	804 Delaware AVE SALISBURY MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Several days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic obstructive pulmonary disease, congestive heart failure, dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 88 to 12/31 19 88, that (I) (we) last saw the deceased alive on 12/31 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles B Silvia Jr — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/31/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles B. Silvia Jr MD

22e. ADDRESS: PGHMC

23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1 7 89	Westover Cemetery	Westover Som MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FOOK'S FUNERAL HOME	P.O. BOX 154 SALISBURY, MD 21801	JAN 4 '89	Julia Davidson-Randall

BP 2

DHMH - 16 60M 7/84 (VRA 15, 4)

020084 JAN 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3831 5

1. DECEASED NAME (TYPE OR PRINT): First: William; Middle: Thomas; Last: Ward, Jr.

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month: 12 Day: 31 Year: 19 88 — 2b. HOUR: 0130 M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Month 11 Day 28 Year 46 — 6. AGE (IN YEARS LAST BIRTHDAY): 42 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month Dec. Day 31 Year 19 88 — 2d. HOUR: 0945 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD

10. CITY OR TOWN OF DEATH: Salisbury — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 329 Camden Ave. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales-clerk — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Wicomico — 13c. CITY OR TOWN: Salisbury — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 329 Camden Avenue 21801

14. FATHER'S NAME: First William; Middle Thomas; Last Ward

15. MOTHER'S MAIDEN NAME: First Madge; Middle Virginia; Last Parsons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-46-2784

17. INFORMANT: father — ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypoglycemia due to hyperinsulinism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: min.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Insulin dependant Diabetes Mellitus — 20 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Thomas C Hill Jr. M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 12/31/88

EXAMINER'S NAME (TYPE OR PRINT): Thomas C. Hill, Jr. M.D. — ADDRESS: Pine Bluff Rd., Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 01-03-89 — 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery — 23d. LOCATION CITY OR TOWN: Salisbury COUNTY: WI STATE: MD

24. FUNERAL DIRECTOR NAME: Holloway Funeral Home — ADDRESS: 501 Snow Hill Rd Salisbury, MD — 25a. DATE REC'D. BY REGISTRAR: JAN 5 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 6

DHMH - 17 (VR A15 ME (5))

020164 JAN 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 3831 6
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the permit for final transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes" in Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Richard	MIDDLE: Gilbert	LAST: Wooters	2a. DATE OF DEATH MONTH DAY YEAR: December 22, 1988	2b. HOUR: 10:30 P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 9, 1918 (1917)	6. AGE (IN YEARS LAST BIRTHDAY): 70 (71) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester County (Worcester Co. 23)	MD.	
10. CITY OR TOWN OF DEATH: Pocomoke	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dividing Creek Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Food Processing		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Worcester	Pocomoke	YES [ ] NO [X]	Dividing Creek Road/21851

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
William / / Wooters	Lillian / Henry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 221-07-8602	17. INFORMANT: Margaret A. Wooters, ADDRESS: Rt. 1, Box 11, Pocomoke, MD 21851

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ANEURYSM VASCULAR ARREST	INSTANTANEOUS
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	5 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)	PRIOR CABG	10 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): (e)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
(e)	(e)	YES [ ] NO [X]	YES [ ] N/A NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
[ ] N/A	N/A 19	N/A
21d. INJURY OCCURRED	**21e. PLACE OF INJURY** (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	**21f. LOCATION** STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	N/A	

22a. I certify that (I) (this hospital) attended the deceased from 7/80, 19____, to 12/22/88, 19____, that (I) (we) last saw the deceased alive on 10/25/88, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN [ ]	MEDICAL DIRECTOR [X]	STAFF PHYSICIAN [ ]	1/3/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	**22e. ADDRESS**			
Ritchie C. Shoemaker, M.D.	1604 Market Street, Pocomoke, MD 21851			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-27-88	Springhill Memory Gardens	Hebron, Wicomico, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Zeller Funeral Home, Salisbury, Maryland	JAN 04 89	June Davidson-Randall

BP 9

DHMH - 16 60M 7/84
(VRA 15, 4)

019775 Jan 17-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38317

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. If manner of death is marked on item 21 is marked or item 18 shows any injury, other than natural disease, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other than natural disease, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
		Eiden		11 27 88	4:45p M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	White	11 27 88			2 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD.	U.S.A.		Baltimore County MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Towson	GBMC 6701 N. Charles St. 21204				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	—	Baltimore	YES ☑ NO ☐	9268 BELLBECK RD. 21234

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
JOSEPH JOHN EIDELL	HOLLY ZAIKEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			HOLLY ZAIKEN	9268 BELLBECK RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	2 hrs.
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)	Non Viable Fetus	2 hrs.
DUE TO, OR AS A CONSEQUENCE OF		
(c)	22 Week Gestation Premature Female	2 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M.D.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11/27/88

23d. PHYSICIAN'S NAME (TYPE OR PRINT)	23a. ADDRESS
Mark Harris, M.D.	2 Luffing Court Balto., MD 21221

23e. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	11/28/88	Greater Balt Med Ctr	Balt. Balt MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[illegible]	6701 N. Charles St. 21204	DEC 9 1988	[signature]

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

016388 DEC 15 88

Item 22a Per M.E. Film G651 CG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR 5/26/89

88 38318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
	Sarah	Jane	Maydwell	12-	7-	19 88	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR
Female	White	9/2/	1960		28 YRS.					12-7-	88	19	6:30P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Md.	USA		Baltimore City MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	1327 E. Patapsco Avenue	Homemaker	Mother

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	---	Baltimore	YES XX NO ☐	1327 E. Patapsco Ave., 21225

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frank	Page	Maydwell, Jr.	Josephine	Mae	Wohnko

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-82-5681	Frank P. Maydwell, Jr.	Box 1165 Sykesville, Md. 21784

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Smoke and soot inhalation

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	6:15PM 12-7-88	Victim of house fire

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	home	1327 E. Patapsco Avenue, Baltimore, City, MD

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection XX, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. KOrell TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER DATE SIGNED 12-7-88

VC EXAMINER'S NAME (TYPE OR PRINT) Margarita A. KOrell, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12/10/88	Cedar Hill Cemetery	Baltimore, A.A. Co., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McCully Funeral Homes	237 E. Patapsco Ave., Baltimore, Md. 21225	DEC 13 1988	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

019023 JAN 13 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 0 038319

1. DECEASED NAME (TYPE OR PRINT): FIRST Rhonda MIDDLE LAST Spence

2a. DATE OF DEATH: MONTH 12 DAY 30 YEAR 88

2b. HOUR 4:26 PM

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: MONTH 09 DAY 09 YEAR 63

6. AGE (IN YEARS LAST BIRTHDAY): 25 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.

10. CITY OR TOWN OF DEATH: Baltimore City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key med. Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland 13b. COUNTY: Baltimore 13c. CITY OR TOWN: Baltimore 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ 13e. STREET ADDRESS / ZIP CODE: 39 N. Catherine St. 21223

14. FATHER'S NAME: FIRST Ronald (George) MIDDLE LAST Spence

15. MOTHER'S MAIDEN NAME: FIRST Barbara MIDDLE LAST Fulp

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ND (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 216-90-9144

17. INFORMANT: Barbara Connor ADDRESS: 167 W. Henrietta St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Adult Respiratory Distress Symptoms

DUE TO, OR AS A CONSEQUENCE OF (c): Sepsis and hypoxia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): 2nd + 3rd Degree Burns to Face, Back and morbid obesity and pregnancy. Right montaggia Fract

19a. DATE OF OPERATION: 12-26-88

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Montaggia Fx and 2°-3° Burns

20a. AUTOPSY? YES ☑ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☑

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH 12 DAY 22 YEAR 88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Fire in House

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Home

21f. LOCATION: STREET 39 N. Catherine CITY OR TOWN Baltimore COUNTY MD STATE

22a. I certify that ☐ (this hospital) attended the deceased from Dec 22, 19 88, to Dec 30, 19 88, that (I) ☐ last saw the deceased alive on Dec. 30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ☐ (did) ☐ view the body after death.

22b. SIGNATURE: Kirsten Hakala DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑

22c. DATE SIGNED: Dec 30, 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kirsten Hakala

22e. ADDRESS: FSKMC 4940 Eastern Ave. Baltimore

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/5/89

23c. NAME OF CEMETERY OR CREMATORY: Dulaney VALLEY CEM

23d. LOCATION: CITY OR TOWN Cockeysville COUNTY STATE Md

24. FUNERAL DIRECTOR: NAME Wm. C. March F/H ADDRESS West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR: JAN 5 1989

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

0242 12 JAN 31 88

12/9/88-Transcribed from original by Sylvia Danich, R.N.

STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 383 20

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Elizabeth A. Walters				7a. DATE OF DEATH MONTH DAY YEAR: 12 7 88	7b. HOUR: 2:43 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 2 8 1929	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Basket Weaver	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Howard	Clarksville	YES ☐ NO ☒	5750 Trotter Road 21029

14. FATHER'S NAME (FIRST / MIDDLE / LAST)	15. MOTHER'S MAIDEN NAME (FIRST / MIDDLE / LAST)
Harvey NMI Fox	Edna NMI Arnold

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	224-30-5697	Richard E.Walters	5750 Trotter Rd. Clarksville,Md.21029

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiovascular Collapse	2 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Sepsis	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Cushing Syndrome	months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Acute Respiratory Distress Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
11/16/88	Cushing Syndrome	YES ☒ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 11/3/88, 19__, to 12/7, 19 88, that (I) (we) last saw the deceased alive on 12/7/88 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Eric D. Strauch MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	12/9/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Eric D. Strauch MD	22 S. Green Street, Balto, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-12-88	St. Louis Cemetery	Clarksville, Howard Md.

24. FUNERAL DIRECTOR (NAME)		25. DATE RECD. BY REGISTRAR	25a. REGISTRAR'S SIGNATURE
HARRY H. WITZKE	4112 Columbia Rd. Ellicott City, Md. 21043	DEC 13 1988	Julia Davidson-Fondale

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

020263 JAN 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 017 5

REG. NO. 88-3831

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST James | MIDDLE James A | LAST Watt/Watts
2a. DATE OF DEATH: MONTH 10 DAY 17 YEAR 89
2b. HOUR 10:30 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH 8 DAY 30 YEAR 13
6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.
10. CITY OR TOWN OF DEATH: Baltimore
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mason F. Lord Nursing Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Seaman

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md. | 13b. COUNTY: ---------- | 13c. CITY OR TOWN: Baltimore | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 3028 Dillon Street 21224

14. FATHER'S NAME: FIRST William | MIDDLE | LAST Watts
15. MOTHER'S MAIDEN NAME: FIRST Margaret | MIDDLE | LAST Flynn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): W.W. 2
16b. SOCIAL SECURITY NO.: 216-09-5086
17. INFORMANT: Emmaline Jankowski | ADDRESS: 529 Forest Lane 21228

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b): Emphysema
DUE TO, OR AS A CONSEQUENCE OF (c): ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary artery disease

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-6, 1989, to 1-17, 1989, that (I) (we) last saw the deceased alive on 1-17, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: John R Burton MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1/18/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John R Burton MD
22e. ADDRESS: 5200 Eastern Ave 21224

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 01-20-89
23c. NAME OF CEMETERY OR CREMATORY: Maryland Veterans'
23d. LOCATION: CITY OR TOWN Garrison Forest | COUNTY Balto. Co. | STATE Md.
24. FUNERAL DIRECTOR: NAME Charles S. Zeiler & Son Inc | ADDRESS 901 S. Conkling St.
25a. DATE REC'D. BY REGISTRAR: JAN 19 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson Registrar

DHMH - 16 60M 7/84 (VRA 15, 4)

BR

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

013450 NOV 17 88 OP STATE REGISTRAR

Item 13 Hospice 11/21/88 KT

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88 REG. NO. 38322

1. DECEASED NAME (TYPE OR PRINT): First: Baby Girl Middle: — Last: Williams
2a. DATE OF DEATH: Month 9 Day 7 Year 88
2b. HOUR: 4:10 PM
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: Month 9 Day 6 Year 88
6. AGE (IN YEARS LAST BIRTHDAY): YRS. — If under 1 year: Months — Days — If under 24 hrs.: Hours 15 Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore
7b. CITIZEN OF WHAT COUNTRY?: US
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Balto City MD.
10. CITY OR TOWN OF DEATH: Baltimore
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Univ of Maryland
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Balt
13b. COUNTY: 1
13c. CITY OR TOWN: Balto
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 712 N. Fulton Ave 21217

14. FATHER'S NAME: First — Middle — Last
15. MOTHER'S MAIDEN NAME: First Darlene Middle — Last Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): severe prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 hours
DUE TO, OR AS A CONSEQUENCE OF (b): Preterm delivery
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-6, 19 88, to 9-7, 19 88, that (I) (we) last saw the deceased alive on 9-7, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: T. Doyle — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑
22c. DATE SIGNED: 9-7-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): T. Doyle
22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal
23b. DATE: 9-15-88
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION: CITY OR TOWN — COUNTY — STATE
24. FUNERAL DIRECTOR: NAME State Anatomy Board ADDRESS Balto., Md.
25a. DATE REC'D BY REGISTRAR: SEP 28 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025174-3/23/89

Dup.FilmG649 3/17/89 kam

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38323

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Terrence	MIDDLE: Pernell	LAST: Galloway, Jr.	2a. DATE OF DEATH MONTH DAY YEAR: 3/10/88	2b. HOUR: 7:15PM	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 2 8 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS: 1 DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key Med.Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 5505 Bowley's La. 21206	
14. FATHER'S NAME FIRST: Terrence	MIDDLE: Pernell	LAST: Galloway Sr.	15. MOTHER'S MAIDEN NAME FIRST: Yvette	MIDDLE: Angela	LAST: Gordon
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Birth record	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic and Renal Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Intra abdominal
DUE TO, OR AS A CONSEQUENCE OF (c): _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ambadas Pathak, M.D.	22e. ADDRESS: 4740 Eastern Avenue, Balto., Md. 21224		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 3/15/88	23c. NAME OF CEMETERY OR CREMATORY: FSKmC	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto., Md.
24. FUNERAL DIRECTOR AND ADDRESS: FSKMC, 4940 Eastern Ave., 21224	25a. DATE REC'D BY REGISTRAR: MAR 17 1988	25b. REGISTRAR'S SIGNATURE: Julia Gordon-Landers	

DUPLICATE

025483 MAR 28 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38324

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
BRITTANY MYRTLE MOY	JANUARY 23 1988	10:57 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
FEMALE	CAUCASIAN	JANUARY 21 1988	YRS	2	

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	UNITED STATES	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	MONTGOMERY 15 MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	N/A	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MAINE	-	LORING AFB	YES ☐ NO ☐	213 ALBROOK COURT 99999

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
DAVID N. MOY	LORNA PEDRICK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	-	N/A	DAVID N. MOY, 213 ALBROOK COURT, LORING AFB

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MAINE 04751 — PREMATURITY (Estimated gestational age - 25 weeks) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 21, 19 88, to JANUARY 23 19 88, that (I) (we) last saw the deceased alive on JANUARY 23 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
J. Nading	MD		2/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. NADING, CDR, MC, USN	NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
	MAR 9 1989	Julia Henderson-Lindsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023968 FEB 23

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88-38325 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Rosie	MIDDLE: L.	LAST: Spencer	2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☒ MONTH: 12 DAY: 26 YEAR: 88	2b. HOUR: M		
3. SEX: F	4. RACE: B 2	5. DATE OF BIRTH MONTH: 10 DAY: 14 YEAR: 26	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YR. MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN:	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 16 YEAR: 89	2d. HOUR: 12:45 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD.				
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 900 Argyle Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic Worker	12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: M	13b. COUNTY	13c. CITY OR TOWN: Balto.	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 900 Argyle Ave 21201			
14. FATHER'S NAME FIRST: William	MIDDLE	LAST: Spencer	15. MOTHER'S MAIDEN NAME FIRST: Irene	MIDDLE	LAST: Spencer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-24-5768	17. INFORMANT: Clayton Leatherberry	ADDRESS: 1638 Braddish Ave			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-17-89

VC EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-22-89	23c. NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery	23d. LOCATION CITY OR TOWN: Balto. COUNTY STATE: MD.
24. FUNERAL DIRECTOR NAME: WM. C. BROWN ADDRESS: 1206 W. North Ave	25a. DATE REC'D. BY REGISTRAR: FEB 22 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017992 DEC -3 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38326

1. DECEASED NAME (TYPE OR PRINT) FIRST: LILLIAN	MIDDLE: E.	LAST: WILKINS	2a. DATE OF DEATH MONTH: DECEMBER	DAY: 23,	YEAR: 1988	2b. HOUR: 409PM
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 6	DAY: 12	YEAR: 36	6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH: BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CHURCH HOME HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNEMPLOYED	12b. KIND OF BUSINESS OR INDUSTRY: NA			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 211 N. COLVIN STREET 21201		
14. FATHER'S NAME FIRST: DAVID	MIDDLE	LAST: WILLIAMS	15. MOTHER'S MAIDEN NAME FIRST: ALICIA	MIDDLE	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-74-3432	17. INFORMANT ADDRESS: ARNITA ROBINSON 5319 BELLEVILLE AVE			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CERBRL VASCULAR ACCIDENT	
DUE TO, OR AS A CONSEQUENCE OF (b)	HGPERTENSION	
DUE TO, OR AS A CONSEQUENCE OF (c)	INSULIN DEPARDENT DIABETES MELLITUS	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: HISTORY OF CARCINOMA OF THE BREAST

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 17, 19 88 to DECEMBER 23, 19 88, that (I) (we) last saw the deceased alive on DECEMBER 23, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: JONATHAN D. KUSHNER	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 12/23/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jonathan D. Kushner	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 12/30/88	23c. NAME OF CEMETERY OR CREMATORY: MOUNT ZION CEMETERY	23d. LOCATION CITY OR TOWN: LANSDOWNE,	COUNTY / STATE: MD
24. FUNERAL DIRECTOR ADDRESS: WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE	25a. DATE REC'D BY REGISTRAR: DEC 29 1988	25b. REGISTRAR'S SIGNATURE: [illegible]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

R BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88-383-27
REG. NO.

1 - FOR STATE REGISTRAR

020165 JAN 23 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
MICHAEL	William	McCURDY	12	27	19 88	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	June 18, 1988		6 / 9		12 27 19 88	7:14 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Garrett County MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett Co. Memorial Hospital	Infant	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Maryland	Garrett	Oakland		1118 Dennett Road 21550

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Stephen	Joseph	McCURDY	Trisha	Ann	GUTHRIE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	---------	Trisha A. McCurdy See #13 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) PENDING

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Chas P. Kokes M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-27-88

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	12/29/88	Ashby Cemetery	Oakland	Garrett Maryland

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Stewart Funeral Home Franklin H. Custer Oakland, Maryland 21550	JAN 3 '89	Julia Davidson-Randall	

07/84 25M BP 301

DHMH - 17 (VR A15 ME (5))

017451 DEC 28 88

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38328

Baby Girl

1. DECEASED NAME (TYPE OR PRINT): Christine Michelle ENNIS
Baby Girl

2a. DATE OF DEATH: 12 01 88 (MONTH DAY YEAR)
2b. HOUR: 2:47 PM

3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: 12 01 88
6. AGE (IN YEARS LAST BIRTHDAY): YRS. IF UNDER 1 YEAR: MONTHS DAYS. IF UNDER 24 HRS.: HOURS 2 MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Howard 13 MD.

10. CITY OR TOWN OF DEATH: Columbia
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard County General Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: A.A.
13c. CITY OR TOWN: Severn
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 8514 Pioneer Dr.

14. FATHER'S NAME: Mike Frank
15. MOTHER'S MAIDEN NAME: Christine Michelle Ennis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): none
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: n/a
17. INFORMANT: Birth record
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b): extreme prematurity 22 weeks gestation
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if ony, which gove rise to immediate cause (a), stating the underlying couse last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SHEMATEK
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal
23b. DATE: 12-15-88
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Balto., Md.
25a. DATE REC'D. BY REGISTRAR: DEC 22 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21a marked or Item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Add.Info.FilmG649 3/16/89 kat

025429 MAR 2089

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38330

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours [illegible]. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Shawness	MIDDLE: LaRue	LAST: Rankin	2a. DATE OF DEATH MONTH DAY YEAR: August 15, 1988
2b. HOUR: 8:00P M			
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: August 15, 1988	6. AGE (IN YEARS LAST BIRTHDAY) YRS: IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN.: 30
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Montgomery General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Mont.		YES ☒ NO ☐	12648 Grey Eagle Ct., 34 00000

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Michale	Eric	Rankin	Laura	Revanna	Love

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Immaturity

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	9/7/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Charles Tuegel, MD	18111 Prince Philip Drive Olney, Maryland 20832

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	8/16/88	Mont. Gen,. Hosp.	Olney, Mont., Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
n/a	MAR 20 1989	[signature]

DHMH - 1650M 1/81 (VRA 15, 4)

024116 FEB 2 1989

FOR STATE REGISTRAR Unknown 89-27

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38331

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Thomas	MIDDLE G.	LAST Langston, Sr.	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒	MONTH DAY YEAR 12-31-88	2b. HOUR M
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 1 24 1952	6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 02-09-89	2d. HOUR 4:00 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne County 17 MD.				
10. CITY OR TOWN OF DEATH Eastern Shore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 50 Yards N. of Bay Bridge	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY Rotamuim				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS 3515 Melody Lane 21207			
14. FATHER'S NAME FIRST Rufus	MIDDLE	LAST Langston, Sr	15. MOTHER'S MAIDEN NAME FIRST Ardelia	MIDDLE	LAST Stpales		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 214-54-5536	17. INFORMANT Helen E.Langston	ADDRESS 3515 Melody Lane			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chest injuries with drowning	
Conditions, if ony, which gove rise to immediate couse (a) stoting the underlying couse lost. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 12-31-88	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject found in water 50 yards from bridge
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 50 yards from Bay Bridge, Queen Annes Co.MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from Noturol couses ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined monner ☐.

ACTUAL SIGNATURE Mario F Golle Jr M.D. TITLE (SPECIFY) ASSISTANT MEDICAL EXAMINER DATE SIGNED 2-10-89

VC EXAMINER'S NAME (TYPE OR PRINT) Mario F.Golle,Jr.MD ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/15/89	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet	23d. LOCATION CITY OR TOWN Owings Mills	COUNTY STATE Md
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR FEB 18 1989	25b. REGISTRAR'S SIGNATURE	

07/84 25M BP

DHMH 17 (VR A15 ME (5))

D07227 SEP 14 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38337

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
JACK	K.	SMITH	8	31	88	10:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
M	W	5	19	16	72 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
	U.S.A.		ANNE ARUNDEL 07 MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
ANNAPOLIS	ANNE ARUNDEL HOSPITAL		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	A.A.	ANNAPOLIS	YES ☒ NO ☐	304 Edgemere Dr. 21403

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		578-07-7372	Frances Smith/304 Edgemere Dr. Annapolis, Md. 21403

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Bronchogenic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 88, to 8-31, 19 88, that (I) (we) last saw the deceased alive on 8-31 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Robert T Peterson	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	8/31/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert T Peterson MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Removal	9-1-88				

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
State Anatomy Board	Balto., Md.	SEP 8 1988	Julia Davidson-Landers

014482 Nov 28-88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 88 38334

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALICE	MIDDLE: M	LAST: BIDGOOD	2a. DATE OF DEATH MONTH DAY YEAR: 11/22/88	2b. HOUR: 1010am M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 10/11/1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Agnes Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: Office		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Howard	Elkridge	YES ☐ NO ☒	5840 Timberview Dr. Elkridge 21227

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
George Lee Griffin	Daisy Ruffin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		224-28-3054	Mr. Vincent Bidgood	5840 Timberview Dr. 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Cardiac arrest due to (2) Metastatic lung cancer
DUE TO, OR AS A CONSEQUENCE OF (b): (3) Carcinoma of the breast
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
H. Tavassolie	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	11/22/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
H. TAVASSOLIE	3455 WILKENS AVE. 21229

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/25/88	Meadowridge Cemetery	Dorsey Howard Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ambrose Funeral Home 1328 Sulphur Spring Road	NOV 23 1988	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

Item 13 per Copy of Birth

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

015707 DEC 388

1 - FOR STATE REGISTRAR 11/3/89 R.T.

REG. NO. 88 38335

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Chatman; Middle; Last	2a. DATE OF DEATH Month 11 Day 19 Year 88	2b. HOUR 9 P M		
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month 11 Day 19 Year 88	6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS: Hours 3 Min. 48	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balto City	MD.
10. CITY OR TOWN OF DEATH: Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): University Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	—	Balto	YES ☒ NO ☐	2121? UNKNOWN 1735 W. North Ave

14. FATHER'S NAME First; Middle; Last	15. MOTHER'S MAIDEN NAME First: Genise; Middle; Last: Chatman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	—		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Nonviable fetus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
—	—		

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
	—	—

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE
	—	—

22a. I **certify** that (I) (this hospital) attended the deceased from Nov 19, 19 88, to Nov 19, 19 88, that (I) (we) last saw the deceased alive on Nov 19, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thomas L Seymour MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	11-20 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Thomas L. Seymour MD	University Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN; COUNTY; STATE
Removal	12-1-88		

24. FUNERAL DIRECTOR NAME	ADDRESS	25. DATE RECEIVED BY REGISTRAR
State Anatomy Board	Balto., Md.	DEC 6 1988

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

011734 NOV -2 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88 38336

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: LEON Middle: O Last: Ford	2a. DATE OF DEATH Month: 10 Day: 30 Year: 88	2b. HOUR: M	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH Month: 10 Day: 3 Year: 41	6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BALTO. CITY	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH: BALTO. CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 4104 PENHURST AVE			
14. FATHER'S NAME First: ERNEST Middle: Last: FORD	15. MOTHER'S MAIDEN NAME First: CORINE Middle: Last: FORD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT: NAOMI JACKSON ADDRESS: 4104 Penhurst Ave

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): bladder carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c): history of intravenous drug abuse
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: history of hepatitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ~~Oct 14 '88~~ 7/15, 19 88, to ~~Oct 14 '88~~ 10/30/88, 19 88, that (I) (we) last saw the deceased alive on Oct 14, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Angela Coeran MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 10/30/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Angela Coeran MD	22e. ADDRESS: 22 South Greene St. Balt. Md. 21201		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11-4-88	23c. NAME OF CEMETERY OR CREMATORY: Maryland Nat. Cemt.	23d. LOCATION CITY OR TOWN: Laurel	COUNTY	STATE: Md.
24. FUNERAL DIRECTOR NAME: Rodney T. Sykes ADDRESS: 4644 Pinewood Rd.	25a. DATE REC'D BY REGISTRAR: OCT 31 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Mundell			

Item 5 & 6 corrected per F.H. film G-648 reb 2/27/89

019864 JAN 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88 38337

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harry	MIDDLE:	LAST: Hurley	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH: 12	DAY: 30	YEAR: 19 88	2b. HOUR: M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 11 DAY: 13 YEAR: 21	6. AGE (IN YEARS LAST BIRTHDAY) ~~67~~ 67 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN:	2c. DATE PRONOUNCED DEAD MONTH: 12	DAY: 31	YEAR: 19 88	2d. HOUR: 2:20P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ UNK NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.				
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6 N. Exeter Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY:				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY:	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1305 N. Fremont Ave. 21217			
14. FATHER'S NAME FIRST: Ernest	MIDDLE:	LAST: Hurley	15. MOTHER'S MAIDEN NAME FIRST: Estelle	MIDDLE:	LAST: Gray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 218-07-4740	17. INFORMANT: Erma Braxton	ADDRESS: 3103 Chelsa Terrace 21216				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hyertensive cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Chas P. Kokes M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 1/1/89

EXAMINER'S NAME (TYPE OR PRINT): Chalres P. Kokes, M.D. ADDRESS: 111 Penn St. Balto.,MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2-18-89	Mt. Zion	Baltimore Co,		Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph L. Russ	Balto., Md. 2222 W. North Ave. 21216	JAN 18 1989	Lucia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITE "DELAYED" OR "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. (RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

002382 JUL 26 88
013458 NOV 17 88

STATE REGISTRAR

Items 13 & 15 per phone - Hosp. 11/31/89 R.T.

Add. Info per BC 8/4/93 KdM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38338

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Alexis ~~Baby Girl~~ — MIDDLE: Nicole — LAST: Johnson Long
2a. DATE OF DEATH — MONTH DAY YEAR: 6-18-88
2b. HOUR: 650 AM
3. SEX: FEMALE
4. RACE: BLACK
5. DATE OF BIRTH — MONTH DAY YEAR: 6 ~~14~~ 88
6. AGE (IN YEARS LAST BIRTHDAY): C — IF UNDER 1 YEAR: MONTHS 0 DAYS 9 — IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): US
7b. CITIZEN OF WHAT COUNTRY?: US
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH: BALTIMORE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FRANCIS SCOTT KEY
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD — 13b. COUNTY: BALTIMORE — 13c. CITY OR TOWN: BALTIMORE — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 3504 Greenspring Ave 21211

14. FATHER'S NAME — FIRST: Rodney — MIDDLE: Alan — LAST: Long
15. MOTHER'S MAIDEN NAME — FIRST: Diane — MIDDLE: Elizabeth — LAST: Johnson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b): E. COLI PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c): PULM. INTERSTISIAL EMPHYSEMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-14, 19 88, to 6-18, 19 88, that (I) (we) last saw the deceased alive on 6-18, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E. Cartyp — DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 7/15/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): E. CARTYP
22e. ADDRESS: 4940 Eastern Ave Baltimore

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation
23b. DATE: 6-20-88
23c. NAME OF CEMETERY OR CREMATORY: Francis Scott Key
23d. LOCATION — CITY OR TOWN: Baltimore — COUNTY: Balt — STATE: MD

24. FUNERAL DIRECTOR — NAME AND ADDRESS: Francis Scott Key Medical Center, 4940 Eastern Ave, Balt. MD. 21224
25a. DATE REC'D. BY REGISTRAR: JUL 25 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death [illegible] may be retained by the hospital or [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

873225

Item 13 per phone Hosp. 1/31/89 R.T.

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38339

0157 06 DEC -8 88

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Marcus — MIDDLE: — LAST: Johnson

2a. DATE OF DEATH — MONTH: 11 — DAY: 17 — YEAR: 88

2b. HOUR: 540 A M

3. SEX: M

4. RACE: Negro

5. DATE OF BIRTH — MONTH: 11 — DAY: 16 — YEAR: 88

6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS — IF UNDER 1 YEAR: MONTHS 0, DAYS 0 — IF UNDER 24 HRS: HOURS 11, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore Md

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Balto. City — MD.

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sinai Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: — 13c. CITY OR TOWN: Balto — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 2651 Hospital St 21218

14. FATHER'S NAME — FIRST: Anthony — MIDDLE: — LAST: Maury

15. MOTHER'S MAIDEN NAME — FIRST: Valerie — MIDDLE: — LAST: Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio respiratory Arrest, Pneumo-pericardium

DUE TO, OR AS A CONSEQUENCE OF (b): Prematurity, Respiratory Distress

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Helen Marie Haney M.D. — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 11/17/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Helen Marie Haney

22e. ADDRESS: Sinai Hospital Balto, 21215

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 12-1-88

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION — CITY OR TOWN — COUNTY — STATE

24. FUNERAL DIRECTOR — NAME: State Anatomy Board — ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: DEC 6 1988

25b. REGISTRAR'S SIGNATURE:

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

019537 JAN 19 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88 38340

1. DECEASED NAME (TYPE OR PRINT): FIRST SYLVESTER MIDDLE LOYAL LAST

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 12 DAY 24 YEAR 88 — 2b. HOUR

3. SEX: M — 4. RACE: BK — 5. DATE OF BIRTH: MONTH 5 DAY 10 YEAR 62 — 6. AGE (IN YEARS LAST BIRTHDAY): 26 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 24 YEAR 88 — 2d. HOUR 2:10a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Johns Hopkins Hospital

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Concrete finisher

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY — 13c. CITY OR TOWN: Balto — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 1200 00000

14. FATHER'S NAME: FIRST Joseph MIDDLE LAST Loyal

15. MOTHER'S MAIDEN NAME: FIRST Marie MIDDLE LAST Hall's

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 215-84-0658

17. INFORMANT: Barbra Peice — ADDRESS: 2543 Preston Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound of back and chest (2)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. 1:30 pm MONTH 12 DAY 24 YEAR 88 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject shot

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): backyard — 21f. LOCATION STREET: 1200 N. Bradford CITY OR TOWN: Baltimore COUNTY: Baltimore STATE: Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ].

ACTUAL SIGNATURE: Margarita A. Korell M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 12-24-88

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 12/30/88 — 23c. NAME OF CEMETERY OR CREMATORY: Eastview Mem. — 23d. LOCATION CITY OR TOWN: Balto COUNTY STATE: MD.

24. FUNERAL DIRECTOR NAME: Jos. F. Miller F.H. — ADDRESS: 1639 N. Broadway

25a. DATE REC'D. BY REGISTRAR: JAN 12 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024503 MAR 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38341

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First ~~Male~~ BABY; Middle GIRL; Last MONTGOMERY
2a. DATE OF DEATH: Month 12; Day 15; Year 88
2b. HOUR: 5:15 PM
3. SEX: FEMALE
4. RACE: BLACK
5. DATE OF BIRTH: Month 12; Day 14; Year 88
6. AGE (IN YEARS LAST BIRTHDAY): YRS; If under 1 year: Months, Days; If under 24 hrs: Hours 22, Min. 30
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH: BALTIMORE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNIV. OF MARYLAND
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: BALT
13c. CITY OR TOWN: BALT.
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: FAMILY'S 1514 EUTAW PL, APT 202 21217
14. FATHER'S NAME: First Arnold; Middle Eugune; Last Payne
15. MOTHER'S MAIDEN NAME: First BETSY; Middle V.; Last MONTGOMERY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES):
17. INFORMANT ADDRESS: Betsy V. Montomery 1514 Futaw Pl. 21217

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): COMPLEX CONGENITAL HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c): TURNER'S SYNDROME
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PREMATURITY.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/14, 19 88, to 12/15, 19 88, that (I) (we) last saw the deceased alive on 12/15, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Martin J. Kelly; DEGREE: MD; ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 12/15/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARTIN J. KELLY
22e. ADDRESS: 22 S. GREENE ST., RM N5W68

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/21/88
23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
23d. LOCATION: CITY OR TOWN Baltimore; COUNTY; STATE Md.
24. FUNERAL DIRECTOR: NAME AND ADDRESS: William C. Brown 1206 West North Ave.
25a. DATE REC'D BY REGISTRAR: 12-30-88
25b. REGISTRAR'S SIGNATURE:

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

019540 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR 8 89

REG. NO. 8 383 42

1. DECEASED NAME (TYPE OR PRINT): FIRST Jamie; MIDDLE Emanuel; LAST Perry

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 11 DAY 2 YEAR 88 — 2b. HOUR

3. SEX: F — 4. RACE: BLK — 5. DATE OF BIRTH: MONTH 10 DAY 15 YEAR 81 — 6. AGE (IN YEARS LAST BIRTHDAY): 7 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 2 YEAR 1988 — 2d. HOUR 11:20 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3104 Garrison Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY — 13c. CITY OR TOWN: Balto. — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 3104 Garrison Ave

14. FATHER'S NAME: FIRST Luther; MIDDLE James; LAST Perry JR

15. MOTHER'S MAIDEN NAME: FIRST Annie; MIDDLE; LAST Hogan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Smoke and soot inhalation and thermal injury

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 10:30PM 11-2-88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Victim of house fire

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 3104 Garrison Avenue, Baltimore City, MD

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection XX, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Julia C Goodin M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 11-3-88

EXAMINER'S NAME (TYPE OR PRINT): Julia C. Goodin, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 11/4/88 — 23c. NAME OF CEMETERY OR CREMATORY: Peace Memorial Inc — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto MD

24. FUNERAL DIRECTOR: Sam Millen & H. — ADDRESS: 1639 N Charles — 25a. DATE REC'D BY REGISTRAR: JAN 12 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, FOR BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

021620 FEB 6 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38343

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Julia / Booker / Reed	2a. DATE OF DEATH MONTH / DAY / YEAR	12 / 09 / 88	2b. HOUR	7.25 AM
3. SEX	F	4. RACE	B	5. DATE OF BIRTH MONTH / DAY / YEAR	11 / 27 / 25
6. AGE (IN YEARS LAST BIRTHDAY)	63 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	VA	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Baltimore City MD.				
10. CITY OR TOWN OF DEATH	Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Homewood Hosp. CTR.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired
12b. KIND OF BUSINESS OR INDUSTRY	N/A				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD		Balto.	YES ☒ NO ☐	1421 N. Aisquith Street 21202

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William / Reed	Lorna / Baker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		223-34-7395	Betty J. Smith 1421 N. Aisquith St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Multi Organ Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Cardio Resp. Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis 2° Perforated Colon

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Peptic ulcer disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
11/11/88 10/26/88	Perforated diverticulitis	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/26 19 88 to 12/09 19 88 that (I) (we) last saw the deceased alive on 12/02 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	12/02/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Bryan Nolan, MD	2724 N. Charles St Balto. MD 21218

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/15/88	RIDGEWAY BAPT. CH. CEM.	DILLWYN, VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE	DEC 13 1988	[signature]

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

016091 DEC 14 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF

88 38344

1 - FOR STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE Frank LAST Shiflett

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 12 DAY 7 YEAR 88 — 2b. HOUR M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 11 DAY 8 YEAR 1986 — 6. AGE (IN YEARS LAST BIRTHDAY): 2 YRS — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 7 YEAR 1988 — 2d. HOUR 6:30P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.

10. CITY OR TOWN OF DEATH: Baltimore — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1327 E. Patapsco Avenue — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Child — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: --- — 13c. CITY OR TOWN: Baltimore — 13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 1327 E. Patapsco Ave., 21225

14. FATHER'S NAME: FIRST David MIDDLE Lee LAST Shiflett, Jr.

15. MOTHER'S MAIDEN NAME: FIRST Sarah MIDDLE Jane LAST Maydwell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-13-9061

17. INFORMANT: Mr. Frank P. Maydwell, Jr. — ADDRESS: Box 1165 21784 Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Smoke and soot inhalation

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS: UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. 6:15PM MONTH 12 DAY 7 YEAR 88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Victim in house fire

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION: STREET 1327 E. Patapsco Avenue, CITY OR TOWN Baltimore City, COUNTY, STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Margarita A. Korell — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 12-8-88

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/10/1988 — 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 23d. LOCATION CITY OR TOWN: Baltimore, COUNTY: A.A. Co., STATE: Md.

24. FUNERAL DIRECTOR NAME: McCully Funeral Homes — ADDRESS: 237 E. Patapsco Ave., Balto., Md. 21225

25a. DATE REC'D. BY REGISTRAR: DEC 13 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

45

018082 JAN

1 - FOR STATE REGISTRAR

REG. NO. 88 383

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Franklin — MIDDLE: — LAST: Smith
2a. DATE OF DEATH — MONTH DAY YEAR: 12-26-88
2b. HOUR: 4:43 PM
3. SEX: M
4. RACE: Black
5. DATE OF BIRTH — MONTH DAY YEAR: 09-05-43
6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS:
IF UNDER 24 HRS. — HOURS / MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARITAL STATUS: MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.
10. CITY OR TOWN OF DEATH: Baltimore
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Liberty Medical Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY:
13c. CITY OR TOWN: Baltimore
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET ADDRESS: 2868 W. Baltimore St. 21223

14. FATHER'S NAME — FIRST MIDDLE LAST: ##### Ernest Smith Sr.
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Mabel Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 251-72-7669
17. INFORMANT — ADDRESS: Paulette Smith 2868 W. Baltimore St.(23)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Pulm. arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Lung Cancer with metastsis
DUE TO, OR AS A CONSEQUENCE OF (c): Sepsis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19:
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE:

22a. I certify that (I) (this hospital) attended the deceased from 11-30- 19 88, to 12-26 19 88, that (I) (we) last saw the deceased alive on 12-26- 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE:
DEGREE: MD, ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑
22c. DATE SIGNED: 12/26/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): AMAE FULE
22e. ADDRESS: Liberty Medical Center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12/30/88
23c. NAME OF CEMETERY OR CREMATORY: Westview Park
23d. LOCATION — CITY OR TOWN COUNTY STATE: Westview Catonsville Md.

24. FUNERAL DIRECTOR — NAME ADDRESS: Estep Bros. F.H. 1300 Eutaw Place
25a. DATE REC'D. BY REGISTRAR: DEC 29 1988
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88 383 46

20066 JAN 23

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use in obtaining burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to removal of body.

1a. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
William	F.	Adams	12	31	88 / 1:40 pM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) / IF UNDER 1 YEAR MONTHS / DAYS / IF UNDER 24 HRS HOURS / MIN.
Male	White	02	25	02	86 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Caroline 05 MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Denton	Caroline Nursing Home	farmer	agriculture

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	Easton		Rt 3 21601

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
William	J. Adams, Jr.	Lillie	May Stoops

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	214-34-5278	Bette M. West Rt 3 Box 309E	Seaford DE 19973

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Renal failure / Sepsis	1 mo.
DUE TO, OR AS A CONSEQUENCE OF (b)	Obstructive uropathy	1 mo.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Coronary artery disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 7/1, 19 88, to 12/31, 19 88, that (I) (~~we~~) last saw the deceased alive on 12/1, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED 12/31/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREA ALLEN	22e. ADDRESS PO B122 GOLDSBORO MD 21636	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	1/3/89	Spring Hill Cem.	Easton	Talbot	MD

24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	JAN 06 '89	Gena Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

016929 DEC 21 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE

88 38347

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): FIRST Philip; MIDDLE E.; LAST Fordham

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 12 DAY 14 YEAR 88 — 2b. HOUR

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: 12-13-1963 — 6. AGE (IN YEARS LAST BIRTHDAY): 25 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: 12-14-88 — 2d. HOUR: 8:00A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey — 7b. CITIZEN OF WHAT COUNTRY?: U S — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline County MD

10. CITY OR TOWN OF DEATH: Marydel — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Maryland/Delaware border

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter — 12b. KIND OF BUSINESS OR INDUSTRY: Lumber

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Del. — 13b. COUNTY: Kent — 13c. CITY OR TOWN: Hartly — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: Rd 1 Box 268 C 9999

14. FATHER'S NAME: FIRST Bernard P.; MIDDLE; LAST Fordham

15. MOTHER'S MAIDEN NAME: FIRST Virginia; MIDDLE Fordham; LAST Nickerson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 221-62-6636

17. INFORMANT: Virginia Nickerson — ADDRESS: Rd1 Box 268 C Hartly, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS: UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. 7:00AM MONTH 12 DAY 14 YEAR 88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/overturned in a pond

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): water

21f. LOCATION: STREET — CITY OR TOWN: Maryland/Delaware border — COUNTY: Caroline County — STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John E. Smialek M.D. — TITLE (SPECIFY): Chief MEDICAL EXAMINER — DATE SIGNED: 12-15-88

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12-17-88 — 23c. NAME OF CEMETERY OR CREMATORY: Sharon Hill — 23d. LOCATION: CITY OR TOWN Dover — COUNTY Kent — STATE Del.

24. FUNERAL DIRECTOR: NAME Thomas R. Trader — ADDRESS 12 Lotus ST 19901 Dover, DELAWARE

25a. DATE REC'D. BY REGISTRAR: DEC 20 1988 — 25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

021996 FEB 89

Item 13 per phone - M.E. 2/16/89 - DAD

T-89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 38348

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Walter	MIDDLE: Boyd	LAST: Proffitt	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 7-28-88	2b. HOUR: M		
3. SEX: Male	4. RACE: Cauca.	5. DATE OF BIRTH MONTH DAY YEAR: Oct 22 1953	6. AGE (IN YEARS LAST BIRTHDAY): 34 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1-14-1989	2d. HOUR: na M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline County MD.				
10. CITY OR TOWN OF DEATH: Denton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): River Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY: None				
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland &	13b. COUNTY: Hunterdon & Caroline	13c. CITY OR TOWN: Flemington & Denton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: ~~Rt. 1 Bx 338 &~~ Orly Drive 21629			
14. FATHER'S NAME FIRST: Norman	MIDDLE: Armour	LAST: Proffitt	15. MOTHER'S MAIDEN NAME FIRST: Mildred	MIDDLE: Ruth	LAST: Hooper		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 148468916	17. INFORMANT ADDRESS: Mildred Johnston, Denton, MD				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pending

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] TITLE (SPECIFY) MEDICAL EXAMINER: Acting Deputy Chief DATE SIGNED: 1-18-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 1/25/89	23c. NAME OF CEMETERY OR CREMATORY: Eastern Shore Crematorium	23d. LOCATION CITY OR TOWN: Georgetown	COUNTY: Sussex STATE: Delaware
24. FUNERAL DIRECTOR NAME / ADDRESS: M Randolph P. Moore Denton, Md 21629	25a. DATE REC'D. BY REGISTRAR: JAN 27 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

07/84 25M BP 324

DHMH - 17 (VR A15 ME (5))

007168 SEP 14 88

Items 2a, 9, G644 10-5-88 hb

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 383 49

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	BENJAMIN G TRAVERS	2a. DATE OF DEATH MONTH DAY YEAR	AUGUST 23, ~~1987~~ 1988	2b. HOUR 10:45PM
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR: August 16, 1918
6. AGE (IN YEARS LAST BIRTHDAY)	70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH	~~Harford~~ Cecil County 07 MD.			
10. CITY OR TOWN OF DEATH	PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): First Mate
12b. KIND OF BUSINESS OR INDUSTRY	MD State Emp.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	Dorchester	13c. CITY OR TOWN: Cambridge
13d. INSIDE CITY LIMITS? YES [ ] NO [XX]		13e. STREET ADDRESS	Dorchester Mobile Park/21613	
14. FATHER'S NAME FIRST / MIDDLE / LAST	Charles G. Travers	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Bessie Mae Lewis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	WWII	16b. SOCIAL SECURITY NO. 212-12-3499
17. INFORMANT	Dorothy A. Travers,	ADDRESS	RFD 1, Box 175F Cambridge, MD 21613	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TRANSITIONAL CELL CANCER OF BLADDER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ([X] this hospital) attended the deceased from MARCH 25, 19 87, to AUGUST 23, 19 88, that [X] (we) last saw the deceased alive on AUGUST 23, 19 88, and that in my [XX] (our) opinion death occurred on the date and hour and from the causes stated above. [X] (We) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [XX]	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	BRUCE SOKOLOFF, M.D.	22e. ADDRESS	VA MEDICAL CENTER, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	8-27-88	23c. NAME OF CEMETERY OR CREMATORY: MD Eastern Shore Veterans, Beulah, Dorchester, MD
23d. LOCATION CITY OR TOWN / COUNTY / STATE				
24. FUNERAL DIRECTOR NAME / ADDRESS	Zeller Funeral Home, East New Market, MD	25a. DATE REC'D BY REGISTRAR	SEP 12 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

D25141 MAR 13 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88 38350

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the local registrar or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Florence E. Tweed			2a. DATE OF DEATH MONTH DAY YEAR	November 5, 1988
				2b. HOUR	5:40A M
3. SEX	Female	4. RACE	Cauc.	5. DATE OF BIRTH MONTH DAY YEAR	Feb. 14, 1900
6. AGE (IN YEARS LAST BIRTHDAY)	88 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PennSylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil County MD.				
10. CITY OR TOWN OF DEATH	Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Calvert Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Delaware	New Castle	Newark	YES ☐ NO ☒	130 W. Park Pl., 19711

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
James Edgar Baylis	Roberta V. Harrar		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		221-10-2669	Francis E. Tweed, St. Charles, IL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Urinary Tract Infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/8 19 79 to 11/5 19 88, that (I) (we) last saw the deceased alive on 10/24 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James R. Dearworth MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11/14/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Dearworth, MD	22e. ADDRESS 167 W. Main St., Newark, DE	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/9/88	Newark Methodist Cem.	Newark, NC. DE
24. FUNERAL DIRECTOR (SIGNATURE)		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Frank C. Mayer, Jr., 121 W. Park Pl. Newark		MAR 9 '89	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

023588 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88 38351

1. DECEASED NAME (TYPE OR PRINT): FIRST Claude; MIDDLE L; LAST Viar

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 9 DAY 3 YEAR 1988 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH July DAY 23 YEAR 45 — 6. AGE (IN YEARS LAST BIRTHDAY): 43 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 9 DAY 3 YEAR 1988 — 2d. HOUR 12:10 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY 12 PM MD

10. CITY OR TOWN OF DEATH: Bel Air — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 723 Roland Avenue — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Disability 100% — 12b. KIND OF BUSINESS OR INDUSTRY: Military

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Bel Air — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 723 Roland Avenue

14. FATHER'S NAME: FIRST Isaac Paterson; MIDDLE; LAST Viar — 15. MOTHER'S MAIDEN NAME: FIRST Mary Frances (Manns); MIDDLE; LAST Viar

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): Viet Nam — 16b. SOCIAL SECURITY NO.: 218-46-4673 — 17. INFORMANT ADDRESS: Claudia V. Trust-Aunt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Seizure disorder
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Head Injury (VietNam War-Marines)
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR UNK 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): While in USMarines-During VietNam War

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.): VietNamWar — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE: Viet Nam War,

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Richard J. Colfer M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 9/5/88

EXAMINER'S NAME (TYPE OR PRINT): Richard J. Colfer, MD ADDRESS: 2013 Trappe Church Rd. Darlington, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 9/7/88 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery — 23d. LOCATION CITY OR TOWN COUNTY STATE: BelAir Harf.Co., Md. 21014

24. FUNERAL DIRECTOR NAME ADDRESS: Foster Funeral Homes BelAir, Md. 21014 Joseph W. Foster, 50 W. Broadway & Wms. St. — 25a. DATE REC'D. BY REGISTRAR: SEP 14 1988 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTED CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP DHMH - 17 (VR A15 ME (5))

007341 SEP 15 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 indicates that Item 18 is due to any injury, or other traumatic event, the medical examiner must be notified of this.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38352

1. DECEASED NAME (TYPE OR PRINT): First Marie Middle L Last Keefer

2a. DATE OF DEATH: Month 9 Day 11 Year 88

2b. HOUR: 7:45 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month 4 Day 7 Year 00

6. AGE (IN YEARS LAST BIRTHDAY): 88 yrs. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours ____ Min. ____

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Howard County 13 MD

10. CITY OR TOWN OF DEATH: Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HOWARD County General Hsp.

12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland 13b. COUNTY: Howard 13c. CITY OR TOWN: Sykesville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 7521 GATHER Road 21784

14. FATHER'S NAME: First Ben Middle Last Poteet

15. MOTHER'S MAIDEN NAME: First Madeline Middle Lutz Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 214-30-6328

17. INFORMANT: Mr. William Keefer ADDRESS: 1921 Victory Drive 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Right Lower Lobe pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2days

DUE TO, OR AS A CONSEQUENCE OF (b): hypoxia + hypercarbia — 2days

DUE TO, OR AS A CONSEQUENCE OF (c): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 887

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: renal failure (acute + chronic) femur fracture (7/88) anemia.

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): —

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept 9, 19 88, to Sept 11, 19 88, that (I) (we) last saw the deceased alive on Sept 11, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Patrick A. Tye DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Sept 11 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PATRICK A. TOYE MD

22e. ADDRESS: 10772 Hickory RIDGE RD COLUMBIA MD 21044.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 09/14/88

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION: CITY OR TOWN Baltimore City COUNTY Maryland STATE

24. FUNERAL DIRECTOR: NAME Ambrose Funeral Home ADDRESS 1328 Sulphur SPring Road

25a. DATE REC'D. BY REGISTRAR: SEP 14 1988

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

008644 SEP 29 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR LOCAL REGISTRAR — REG. NO. 88 38353

1. DECEASED NAME (TYPE OR PRINT) FIRST: MICHAEL	MIDDLE: IVAN	LAST: HAKE	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☑ MONTH DAY YEAR: 09 21 1988	2b. HOUR: P M	
3. SEX: Male	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: 05 01 43	6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 09 22 1988	2d. HOUR: 12 33 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County, MD. 15		
10. CITY OR TOWN OF DEATH: Germantown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12905 Poppyseed Ct	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postal Carrier	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Postal Service		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Germantown	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 12905 Poppyseed Ct 20874	
14. FATHER'S NAME FIRST: Ivan	MIDDLE: W.	LAST: Hake	15. MOTHER'S MAIDEN NAME FIRST: Edythe	MIDDLE: A.	LAST: Schumacher
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Korea	16b. SOCIAL SECURITY NO.: 213 40 5278	17. INFORMANT: (Mother) Edythe A. Hake	ADDRESS: 1510 Sanford Road Silver Spring, Md. 20902	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE
Conditions, if any, which gave rise to immediate couse (a) stoting the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Depression — INDEF
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: PM P.M. 09 21 1988	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Gunshot in Head
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home	21f. LOCATION STREET: 12905 Poppyseed Ct CITY OR TOWN: Germantown COUNTY: Mont STATE: Md

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Dept MEDICAL EXAMINER DATE SIGNED: 09/22/88

EXAMINER'S NAME (TYPE OR PRINT): Francis C Mayle ADDRESS: 8200 Wisconsin Ave Bethesda Md 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: September 23, 1988	23c. NAME OF CEMETERY OR CREMATORY: Montgomery Crematorium, Inc.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bethesda/Montgomery/Maryland
24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert A. Pumphrey Funeral Homes/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland	25a. DATE REC'D. BY REGISTRAR: SEP 28 1988	25b. REGISTRAR'S SIGNATURE: [signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0008144 SEP 29 89

RELEASED BY M.E.
022650 FEB 14 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 88 38354

1. DECEASED NAME (TYPE OR PRINT): ANNE JACOBSON RIVERA
2a. DATE OF DEATH: AUGUST 30 1988
2b. HOUR: 12:03 PM
3. SEX: FEMALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MARCH 21 1915
6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: MONTGOMERY MD.
10. CITY OR TOWN OF DEATH: BETHESDA
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): NAVAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NURSE
12b. KIND OF BUSINESS OR INDUSTRY: RESEARCH

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: KENSINGTON
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 3913 DUNNEL LANE 20895

14. FATHER'S NAME: JOHN JACOBSON
15. MOTHER'S MAIDEN NAME: EMMA NORDSTROM
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): –
16b. SOCIAL SECURITY NO.: 577-42-3609
17. INFORMANT ADDRESS: JOSE A. RIVERA, 3913 DUNNEL LANE, KENSINGTON, MD 20895

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from AUGUST 29, 19 88, to AUGUST 30, 19 88, that (I) (we) last saw the deceased alive on AUGUST 30, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature]
DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 30 Aug 88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. E. LEWIS, LT, MC, USNR
22e. ADDRESS: NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 9/2/88
23c. NAME OF CEMETERY OR CREMATORY: Arl. Nat'l. Cem.
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arl., VA
24. FUNERAL DIRECTOR (NAME): Joseph Gawler's Sons, Inc.
5130 WI Ave. NW Wash., DC 20016
25a. DATE REC'D BY REGISTRAR: 9-6-88
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81
(VRA 15, 4)

022556 FEB 13 89

P - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38355

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Amanda	Middle: nmn	Last: Yates	2a. DATE OF DEATH Month/Day/Year: 12/27/88	2b. HOUR: 11:25 A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month/Day/Year: 12 27 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours: 1 / Min.: 25
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): n/a	12b. KIND OF BUSINESS OR INDUSTRY: n/a		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Laurel	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 104 Morris Dr 301 Laurel Md 20707	
14. FATHER'S NAME First: David	Middle:	Last: Yates	15. MOTHER'S MAIDEN NAME First: Paula	Middle: A	Last: Bowen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO.: None	17. INFORMANT ADDRESS: Paula A. Bowen(mother) same as 13e		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHYXIA NEONATORUM — Approximate interval between onset and death: 1½ hr
DUE TO, OR AS A CONSEQUENCE OF (b): EXTREME IMMATURITY — 1½ hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PREMATURE RUPTURE OF MEMBRANES

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): —	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/17, 19 88, to 12/27, 19 88, that (I) (we) last saw the deceased alive on 12/22, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/29/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): STEVEN P. WYNN	22e. ADDRESS: HOLY CROSS HOSP 1500 FOREST GLEN RD, SILVER SPRING		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/17/89	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Silver Spring, Maryland
24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. ADDRESS: 1331 Rockville Pike, Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR: JAN 14 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

007803 SEP 20 '88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38356

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Gerald	MIDDLE: M.	LAST: Duley	2a. DATE OF DEATH MONTH: 9	DAY: 15	YEAR: 1988
2b. HOUR: 6:33p M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 3 DAY: 10 YEAR: 59	6. AGE (IN YEARS LAST BIRTHDAY): 29 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Ctr.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY: School Board		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Temple Hills	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 5935 Fisher Rd. Apt 12	
14. FATHER'S NAME FIRST: Lawrence	MIDDLE	LAST: Duley	15. MOTHER'S MAIDEN NAME FIRST: Elizabeth	MIDDLE	LAST: Hall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-62-9322	17. INFORMANT: Jan Arlene Duley	ADDRESS: as in item 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Brain Tumor — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Multiple Pulmonary Emboli

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) ~~XXXXXXX~~ attended the deceased from Sept. 3, 19 88, to Sept. 15, 19 88, that (I) ~~XX~~ last saw the deceased alive on Sept. 15, 19 88, and that in (my) ~~XX~~ opinion death occurred at the date and hour and from the causes stated above, (I) ~~XX~~ (did) ~~XXXX~~ view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 9-15-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Philip Wisotsky M.D.

22e. ADDRESS: 6188 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9-19-88	23c. NAME OF CEMETERY OR CREMATORY: St. Thomas Ch. Cem.	23d. LOCATION CITY OR TOWN: Croom	COUNTY: P.G. STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.	25a. DATE REC'D. BY REGISTRAR: SEP 19 1988	25b. REGISTRAR'S SIGNATURE: [signature]		

BP

DMMH - 16 50M 1/81 (VRA 15, 4)

022606 FEB 1 | 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88 38357

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or else

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
David	Eugene	Hamilton Jr.	September 21, 1988	6:37PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Black	Sept. 21, 1988			1 00

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Cheverly	USA		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cheverly	Prince George's Hospital Center	--	--

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
-- MD	Prince George's	Landover	YES ☐ NO ☐	1109 Capital View Drive #533

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
David Eugene Hamilton	Pamela Yvette Harris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		NONE	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Unknown (8 days old) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	22c. DATE SIGNED
Myoung Woon Lee M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Myoung Woon Lee, MD PGHC	Prince George's Hospital Center 3001 HOsp. Dr./Cheverly, MD 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
		HOSPITAL	

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
	FEB 13 1989	Julia Davidson-Randall

007449 SEP 1988

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-3835

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Michael — MIDDLE: Manuel — LAST:

2a. DATE OF DEATH KNOWN / ESTIMATED — MONTH DAY YEAR: Sept. 4 1988 — 2b. HOUR: M

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH MONTH DAY YEAR: Sept 24 13 — 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: Sept 14 1988 — 2d. HOUR: 1120 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY):

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Mt Rainier

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4507 Russell Ave Apt 3

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Prince George's — 13c. CITY OR TOWN: Mt Rainier — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 4507 Russell Ave, Apt 3 20782

14. FATHER'S NAME FIRST MIDDLE LAST:

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 184058230?

17. INFORMANT ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Inf.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).: None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John S. Rogers M.D. — TITLE (SPECIFY): Asst. MEDICAL EXAMINER

DATE SIGNED: Sept 14 1988

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — 23b. DATE: 9-14-88 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: SEP 14 1988 — 25b. REGISTRAR'S SIGNATURE: Julia Davison-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____

DHMH - 17 (VR A15 ME (5))

025585 APR 12 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38359

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FN 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: John	MIDDLE: Allan	LAST: Hancock	2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐	MONTH DAY YEAR: 12-17-88	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH 10 DAY 23 YEAR 57	6. AGE (IN YEARS LAST BIRTHDAY): 31 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 12-17-1988	2d. HOUR: 12:55 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore County MD.				
10. CITY OR TOWN OF DEATH: Edgemere	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6809 River Drive Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bond Distributor	12b. KIND OF BUSINESS OR INDUSTRY: Warehouse				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE: Maryland	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Edgemere	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 6809 River Drive Road 21219			
14. FATHER'S NAME: FIRST Ernest	MIDDLE A.	LAST Hancock, Sr.	15. MOTHER'S MAIDEN NAME: FIRST Martha	MIDDLE A.	LAST Bielawski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-76-6985	17. INFORMANT ADDRESS: Karen Hancock 6809 River Drive Road 21219				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Contact shotgun wound to the chest
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 12-17-88	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Self inflicted
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home	21f. LOCATION: STREET 6809 River Drive Rd. CITY OR TOWN Baltimore COUNTY County STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐. REISSUED 4-3-89

ACTUAL SIGNATURE OF M.D. [signature] TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-18-88

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

VC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/21/88	23c. NAME OF CEMETERY OR CREMATORY: Gardens of Faith	23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Dundalk, MD 21222	25a. DATE REC'D. BY REGISTRAR: APR 4 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

VOID

DEATH

ETTA CONEY

certificate no.: 88-38360

006545 SEP -8 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38361

1. DECEASED NAME (TYPE OR PRINT) — FIRST: PAULETTE — MIDDLE: — LAST: DAY

2a. DATE OF DEATH: MONTH SEPTEMBER DAY 05 YEAR 1988 — 2b. HOUR 9:07 P M

3. SEX: FEMALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH 12 DAY 23 YEAR 50 — 6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW JERSY — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD

10. CITY OR TOWN OF DEATH: BALTIMORE — 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): THE JOHNS HOPKINS HOSPITAL — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DOMESTIC — 12b. KIND OF BUSINESS OR INDUSTRY: n/a

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE — 13b. COUNTY — 13c. CITY OR TOWN — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS

14. FATHER'S NAME FIRST: PAUL MIDDLE: POPE LAST: — 15. MOTHER'S MAIDEN NAME FIRST: GEORGIA MIDDLE: TAYLOR LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO: 136 40 5986 — 17. INFORMANT: JANICE FULLER — ADDRESS: 1113 1st. AVE. ASBURY PARK N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	one min.
DUE TO, OR AS A CONSEQUENCE OF	Sepsis	12 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)	Acquired Immunodeficiency Syndrome	18 m/o's

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Disseminated Intravascular Coagulation

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES ☐ NO ☑ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/25 19 88 to 9/5 19 88, that (I (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we)) did (did not) view the body after death.

22b. SIGNATURE: [signature] MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 9/5/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James Aang MD — 22e. ADDRESS: Johns Hopkins Hosp, Balto, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 9-9-88 — 23c. NAME OF CEMETERY OR CREMATORY: WHITE RIDGE CEM. — 23d. LOCATION CITY OR TOWN: EATONTOWN — COUNTY — STATE: NEW JERSEY

24. FUNERAL DIRECTOR NAME: JACKSON FUNERAL HOME — ADDRESS: 242 NEPTUNE BLV. NEPTUNE, NEW JERSEY — 25a. DATE RECD. BY REGISTRAR: SEP 07 1988 — 25b. REGISTRAR'S SIGNATURE: Gina Davidson-Rondello

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Please complete items 1 through 22 as required by law. Please see that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician and retained by the hospital.

TO FUNERAL DIRECTOR: After this certificate is completed and signed, it should be delivered to the funeral director. Page 3 should be detached for use at the burial-transit permit. Then please have the certificate completed and signed. Parts 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. DATE PAULETTE 12/23/50

IMPORTANT: If item 21 is marked or items 18 show any injury, or if the medical examiner must be notified at once

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

13674 NOV 18 88

38362

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby	MIDDLE: Boy	LAST: Powell	2a. DATE OF DEATH MONTH: 11 DAY: 11 YEAR: 88	2b. HOUR: 9 AM	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: 11 DAY: 11 YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: 6 MIN.: 10
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto.	7b. CITIZEN OF WHAT COUNTRY?: NA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ NA	9. BALTIMORE CITY OR COUNTY OF DEATH: City	MD.	
10. CITY OR TOWN OF DEATH: Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frances Scott Key Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NA	12b. KIND OF BUSINESS OR INDUSTRY: NA		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: —	13b. COUNTY: —	13c. CITY OR TOWN: —	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: — 00000	
14. FATHER'S NAME FIRST: UNKNOWN	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST: Sheuria	MIDDLE	LAST: Powell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): —	16b. (IF YES, GIVE WAR OR DATES): —	SOCIAL SECURITY NO.: —	17. INFORMANT ADDRESS: 1408 Langley Way Apt 201 Hyattsville Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): ABORTUS - 200gram fetus.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Eileen B. Davis	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE RECD. BY REGISTRAR: NOV 17 1988	25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

025569 APR 10 88

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38363

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: BABY BOY	MIDDLE	LAST: PRATTIS	2a. DATE OF DEATH MONTH DAY YEAR: 12 10 88	2b. HOUR: 4:21 PM	
3. SEX: M	4. RACE: B	5. DATE OF BIRTH MONTH DAY YEAR: 12 9 88	6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS.	IF UNDER 1 YEAR MONTHS: 0 DAYS: 0	IF UNDER 24 HRS. HOURS: 16 MIN.: 50
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BALTIMORE	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SINAI HOSPITAL of BALTIMORE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: —	13b. COUNTY: —	13c. CITY OR TOWN: —	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: —	00000
14. FATHER'S NAME FIRST: SEAN	MIDDLE	LAST: TODD	15. MOTHER'S MAIDEN NAME FIRST: TAMMY	MIDDLE	LAST: PRATTIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): —	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: —	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	12 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)	Severe hyaline membrane disease	16 HOURS
DUE TO, OR AS A CONSEQUENCE OF (c)	extreme prematurity	16 HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9 DEC 19 88, to 10 DEC 19 88, that (I) (we) last saw the deceased alive on 10 DEC 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dan Wech — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 12/10/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DAN WECHSLER, MD — 22e. ADDRESS: SINAI HOSPITAL, BALTIMORE, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 12-12-88	23c. NAME OF CEMETERY OR CREMATORY: SINAI HOSPITAL	23d. LOCATION CITY OR TOWN: BALTO / COUNTY: — / STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: SINAI HOSPITAL 240 W. PRESTON AVE	25a. DATE REC'D. BY REGISTRAR: 12-17-88	25b. REGISTRAR'S SIGNATURE:	

25570 APR 10 88

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38364

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before case is released.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby boy	MIDDLE	LAST: Smalls	2a. DATE OF DEATH MONTH DAY YEAR: 12/29/88	2b. HOUR: 741 PM M	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 12 29 88	6. AGE (IN YEARS LAST BIRTHDAY): 6 hrs YRS.	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS HOURS MIN.: 6 51
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balt. City	MD.	
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sinai Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 00000	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardio pulmonary arrest	1°
DUE TO, OR AS A CONSEQUENCE OF (b)	hyaline membrane disease	5°
DUE TO, OR AS A CONSEQUENCE OF (c)	extreme prematurity	6°

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1250 pm 12/28/ 19 88, to 741 pm 12/29 19 88, that (I) (we) last saw the deceased alive on 12/29/88 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Brad Robinson	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 12/29/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): BRADLEY WILLIAMS ROBINSON	22e. ADDRESS: SINAI Hospital of Baltimore		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 1-30-89	23c. NAME OF CEMETERY OR CREMATORY: Sinai Hospital	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: 2401 W. Belvedere Ave Sinai Hospital	25a. DATE REC'D. BY REGISTRAR: 1-10-89	25b. REGISTRAR'S SIGNATURE		

025558 APR-2-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38365

1. DECEASED NAME (TYPE OR PRINT): Steven A. Taylor

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ — MONTH 11 DAY 4 YEAR 88

2b. HOUR: M

3. SEX: M

4. RACE: W 1

5. DATE OF BIRTH: MONTH 9 DAY 14 YEAR 58

6. AGE (IN YEARS LAST BIRTHDAY): 30 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 4 YEAR 88

2d. HOUR: 4:00P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TEXAS

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): University Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNEMPLOYED

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY:

13c. CITY OR TOWN: BALTIMORE

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 209 BRIDGEVIEW RD. 21225

14. FATHER'S NAME: CLAUDE E. TAYLOR

15. MOTHER'S MAIDEN NAME: DEXI BLAYLOCK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b. (IF YES, GIVE WAR OR DATES) SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: RONNY GENE TAYLOR, CALL, TEXAS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX ☑ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 1:04AM 11-4-88

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject shot

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX ☑

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION STREET CITY OR TOWN COUNTY STATE: 209 Bridgeview Road, Baltimore City, MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX ☑, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XXX ☑, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D.

TITLE (SPECIFY): Assistant MEDICAL EXAMINER

REISSUED 3-14-89

DATE SIGNED: 11-5-88

EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 11-8-88

23c. NAME OF CEMETERY OR CREMATORY: KIRBYVILLE CEMETERY

23d. LOCATION CITY OR TOWN COUNTY STATE: KIRBYVILLE TEXAS

24. FUNERAL DIRECTOR: Russ Funeral Home ADDRESS: Kirbyville Memorial Funeral Home P.O.Box 516 Kirbyville, Texas 75956

25a. DATE REC'D BY REGISTRAR: NOV 10 1988

25b. REGISTRAR'S SIGNATURE: Julia Dendon-Kendall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025584

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 88-38367

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒	MONTH	DAY	YEAR	2b. HOUR			
	Roy	Locher	Williams		10	28	88	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR
Male	White	6	6	32	56 YRS.						10-28-1988	7:40P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Worcester County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
	Waters off Ocean City	Sales Manager	Automotive

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Balto. Co.		YES ☐ NO ☒	6423 Pinehurst Rd. 21212

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	H.C.	Williams	Edna	May	Gromer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		216-28-8775	Atty H.L. Allers Jr. OCME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8415

IMMEDIATE CAUSE (a) Multiple injuries -- BODY NOT RECOVERED

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	7:40PM 10-28-88	Pilot in plane crash

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	plane - water	Waters off Ocean City, Worcester County, MD

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐ per Court Order issued 3-7-89

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
	APR 7 1989	Julie Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025629 APR 20 19

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38368

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
RUTH	Elizabeth	ETZLER	FEBRUARY 18, 1988	7:29A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	June 26, 1920	~~68~~ 67 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE JOHNS HOPKINS HOSPITAL	Sales associate	retail clothing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Frederick	YES ☐ NO ☒	301 Canberra Court, 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Millard	Fillmore	Rice	Ruth		Darner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	214-10-5005	Darryl N. Etzler,	301 Canberra Court Frederick, Md. 21701

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	Immediate
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic renal failure	Months
DUE TO, OR AS A CONSEQUENCE OF (c)	Cardiomyopathy	Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/4, 19 89, to 2/18, 19 89, that (I) (we) last saw the deceased alive on 2/18, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Mun K. Hong, MD	Johns Hopkins Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 22, 1989	Mt. Olivet Cemetery	Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Keeney and Basford Funeral Home	106 East Church St., Frederick, Md. 21701	FEB 21 1989	Julia Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed as fully as possible. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be detached for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

015669 DEC-8 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38369

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Baby	Boy	Green	11	10	88	10:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
Male	Black	11	10	88				2	15

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Balto	NA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NA	City MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
	Francis Scott Key Medical Center	NA	NA

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
			YES ☐ NO ☐	

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
unknown			Terrell		Green

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Extreme prematurity (Preterm) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	11-10-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. Brown MD	F. S. Key Hosp.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
cremation	11-14-88	FSKMC	Balt.	Balt.	Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FSKMC 4940 Easton Ave Balt. Md. 21224	NOV 17 1988	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

025628 APR 2089 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38370

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Nellie	Middle: V.	Last: Hargett	2a. DATE OF DEATH Month: 12	Day: 3	Year: 88
2b. HOUR: 10:20 P M					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month: 10 Day: 18 Year: 00	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Caton Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Allied Bag factory		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Howard	Woodbine	YES ☐ NO ☒	1850 St. Michaels Rd. 21797

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
George	Margaret E.	UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	220-03-5686	Pauline Riggleman 4321 Salem Bottom Rd.	21157

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	probable cardiac arrhythmia	
DUE TO, OR AS A CONSEQUENCE OF (b)	atherosclerotic coronary artery disease	
DUE TO, OR AS A CONSEQUENCE OF (c)	natural processes	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May 7, 19 87 to March 12, 19 89, that (I) (we) last saw the deceased alive on March 12, 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Jerry D. Skarbeck, M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	3-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Skarbeck, Jerry D.	3708 Mountain road Pasadena, MD 21122

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-15-89	Poplar Springs Cemetery	Woodbine Howard MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hubbard Funeral Home, INc. 4107 Wilkens Ave. 21229	MAR 15 1989	Julia Davidson Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

MAR 15 1909

017311 DEC 28 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38371

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DECEASED NAME (TYPE OR PRINT) FIRST: Hicks	MIDDLE: Baby	LAST: Girl	2a. DATE OF DEATH MONTH DAY YEAR: 10/16/88	2b. HOUR: 523 PM	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 10 14 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS DAYS: 2	IF UNDER 24 HRS. HOURS MIN: 5 27
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sinai Hospital of Maryland	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Balto. City	13b. COUNTY	13c. CITY OR TOWN: City	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 0000	
14. FATHER'S NAME FIRST: Unknown	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST: Bonnie	MIDDLE	LAST: Hicks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Unknown	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Chart information	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Metabolic derangements

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Extreme prematurity

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Probable intraventricular hemorrhage, Pulmonary immaturity, Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from October 14, 19 88, to October 16, 19 88, that (I) (we) last saw the deceased alive on October 16, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Lauren J Bogue	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 10/16/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lauren L. Bogue	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 10-24-88	23c. NAME OF CEMETERY OR CREMATORY: Sinai Hospital	23d. LOCATION CITY OR TOWN: Balto	COUNTY: MD	STATE
24. FUNERAL DIRECTOR NAME: Sinai Hospital	ADDRESS: 2401 W Belvedere Ave	25a. DATE REC'D. BY REGISTRAR: DEC 27 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall		

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025631 APR 20-88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38372

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Lawrence	MIDDLE: E.	LAST: Shipley	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH 12 DAY 30 YEAR 19 88	2b. HOUR M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: MONTH 2 DAY 5 YEAR 27	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 14 YEAR 19 89	2d. HOUR 10:42A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD			
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1637 S. Hanover Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 1637 S. Hanover St. 21230		
14. FATHER'S NAME: FIRST / MIDDLE / LAST			15. MOTHER'S MAIDEN NAME: FIRST / MIDDLE / LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cachexia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes, M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 1-15-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: 1-30-89	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR: State Anatomy Board	ADDRESS: Balto., Md.	25a. DATE REC'D. BY REGISTRAR: FEB 06 1989	25b. REGISTRAR'S SIGNATURE: Gertie Davidson-Kendall	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017300 DEC 20 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38373

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby	MIDDLE: Boy	LAST: Simpson (Mira)	2a. DATE OF DEATH MONTH DAY YEAR: 10 / 25 / 88	2b. HOUR: 2:25 P M	
3. SEX: M	4. RACE: B	5. DATE OF BIRTH MONTH DAY YEAR: 10 / 24 / 88	6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS	IF UNDER 1 YEAR MONTHS: DAYS: 1	IF UNDER 24 HRS. HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City	MD.	
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sinai Hospital of Baltimore	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ø	12b. KIND OF BUSINESS OR INDUSTRY: Ø		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 00000	
14. FATHER'S NAME FIRST: Lloyd	MIDDLE	LAST: Holmes	15. MOTHER'S MAIDEN NAME FIRST: Mira	MIDDLE	LAST: Simpson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS: + Chart Information			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure / Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 32 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Prematurity
DUE TO, OR AS A CONSEQUENCE OF (c): Possible Intraventricular Hemorrhage

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 10/24, 19 88, to 10/25, 19 88, that I (we) last saw the deceased alive on 10/25/88, 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Janelle Sandford MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: 10/25/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Janelle Sandford, MD	22e. ADDRESS	

23a. BURIAL CREMATION REMOVAL (SPECIFY)	23b. DATE: 10-31-88	23c. NAME OF CEMETERY OR CREMATORY: Sinai Hospital	23d. LOCATION CITY OR TOWN: Balto / COUNTY / STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Sinai Hospital 2401 W. Belvedere Ave	25a. DATE REC'D. BY REGISTRAR: DEC 27 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rankin	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025635 MAY 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38374

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST: UNKNOWN #88-34

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☒: MONTH 3 DAY 14 YEAR 1988

2b. HOUR: M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH / DAY / YEAR

6. AGE (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD — MONTH 3 DAY 24 YEAR 1988

2d. HOUR: 1:15P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): pier - 1001 E. McComas Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS

14. FATHER'S NAME — FIRST / MIDDLE / LAST

15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
Conditions, if any, which gave rise to immediate cause (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH 3 DAY 14 YEAR 1988

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject recovered from water

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): water

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE: Patapsco Branch of Harbor, Balto. City, MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE: Chief P. Kokes M.D. TITLE (SPECIFY): Chief MEDICAL EXAMINER DATE SIGNED: 3/25/88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn St. Balto. MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 4-10-89

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION — CITY OR TOWN / COUNTY / STATE

24. FUNERAL DIRECTOR — NAME: State Anatomy Board ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: MAY 4 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lundeen

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

013192 NOV 15 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88-38375

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 DECEASED NAME (TYPE OR PRINT)	FIRST Mary	MIDDLE M.	LAST Kase	2a DATE OF DEATH MONTH 11	DAY 7 YEAR 88
2b HOUR 10 a M					
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 19 YEAR 1890	6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH INSTITUTION, GIVE STREET ADDRESS) Stella Maris	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETERIAL	12b KIND OF BUSINESS OR INDUSTRY RAYMOND INT'L.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS
MD.	BALTIMORE		YES ☐ NO ☒	YORK RD. 21204

14. FATHER'S NAME	15 MOTHER'S MAIDEN NAME	
FIRST HENRY MIDDLE LAST YIENGER	FIRST WILHELMINA MIDDLE LAST GIES	

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b (IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No		212-01-1668	MARY ELLEN YIENGER	20 WHETSTONE DRIVE #4 GAITHERSBURG, MD. 20877

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(b) DEMENTIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from 8/1 19 86 to 11/7 19 88, that (I) (we) last saw the deceased alive on 11/7 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
Carla S. Alexander MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
Carla S. Alexander	

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL		BALTIMORE NAT'L. CEM.	BALTIMORE MD

24 FUNERAL DIRECTOR	ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
John Miller Slack	SLACK FUNERAL HOME ELLICOTT CITY MD 21043	NOV 14 1988	Lee Davidson-Kendall

016357 DEC 15 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38376

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby	MIDDLE: Boy	LAST: Terry	2a. DATE OF DEATH MONTH DAY YEAR: 12/3/88	2b. HOUR: 3:15pm	
3. SEX: Male	4. RACE: B 2	5. DATE OF BIRTH MONTH DAY YEAR: 12/ 3 88	6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS: 2 / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH: TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Baltimore Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: BALTIMORE	13c. CITY OR TOWN: BALTIMORE	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET ADDRESS: 2135 St. Lukes Ln. 21207	
14. FATHER'S NAME FIRST: MICHAEL	MIDDLE	LAST: DAVID	15. MOTHER'S MAIDEN NAME FIRST: DONNA	MIDDLE	LAST: TOWNES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): IMMATURITY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/3, 1988, to 12/3/ 1988, that (I) (we) last saw the deceased alive on 12/3 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Howard L Siegel MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 12/5/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): HOWARD L. SIEGEL, M.D.	22e. ADDRESS: 6701 N. CHARLES ST., BALT., MD. 21204	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 12/5/88	23c. NAME OF CEMETERY OR CREMATORY: GBMC	23d. LOCATION CITY OR TOWN / COUNTY / STATE: 6701 N. Charles St. 21204
24. FUNERAL DIRECTOR NAME: Howard L Siegel MD	ADDRESS: 6701 N. Chas. St. 21204	25a. DATE REC'D. BY REGISTRAR: DEC 12 1988	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

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FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38377

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Funeral Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
ENA	Kate	EARLY	12 - 1 - 88	2:20 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	White	May 10, 1906	82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina	U.S.A.		MONTGOMERY CO. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	SUBURBAN		Housewife		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD.	MONTGOMERY	CHEVY CHASE	YES ☐ NO ☐	3400 ROLLING COURT	20815

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Louis C.		Stokes	Nannie		Mitchell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		246-30-6446A	Nancy E. Pearlman	(same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO-RESPIRATORY FAILURE	HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)	ASPIRATION	DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	STROKES; MULTI-INFARCT DEMENTIA	YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DEMENTIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/27, 19 88, to 12/1, 19 88, that (I) (~~saw~~) last saw the deceased alive on 12/1, 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~saw~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD, FCCP	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EDWARD S. MEHLMAN	9410 OLD GEORGETOWN ROAD, BETHESDA

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-3-88	Stoney Creek Cemetery	Powellsville N.C.

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[signature]	Thomas D. Fletcher & Son, Inc. 254 East Main Street Westminster, Md. 21157	DEC 7 '88	Julia Davidson-Randall

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

014630 NOV 25 '88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38378

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the local registrar or medical examiner should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed to the state registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMER	MIDDLE: HAROLD	LAST: Hitch	2a. DATE OF DEATH MONTH DAY YEAR: November 23, 1988	2b. HOUR: 0110 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 10, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SALISBURY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CARPENTRY	12b. KIND OF BUSINESS OR INDUSTRY: BUILDING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Fruitland	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET ADDRESS: UNKNOWN 21826	
14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest, Pneumonia	5'
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic obstructive lung disease	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Mild Cardiac enlargement Bleeding

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-[illegible]-87 to 11-23-88 that (I) (we) lost saw the deceased alive on 11-23-88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William A Ellis	DEGREE: MD — ATTENDING PHYSICIAN X / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED: 11-23-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wilber R. Ellis	22e. ADDRESS: 100 POwer Street, Salisbury, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 11-26-88	23c. NAME OF CEMETERY OR CREMATORY: ZION CEMETERY	23d. LOCATION CITY OR TOWN: EDEN / COUNTY: WI / STATE: MD
24. FUNERAL DIRECTOR NAME: Holloway Funeral Home, PA ADDRESS: 501 Snow Hill Rd Salisbury, MD	25a. DATE REC'D BY REGISTRAR: NOV 25 1988	25b. REGISTRAR'S SIGNATURE: [signature]	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

015675 DEC -8 88 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38379

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BB	MIDDLE:	LAST: Burrell	2a. DATE OF DEATH MONTH: 10 DAY: 11 YEAR: 88	2b. HOUR: 8:55 PM	
3. SEX: male	4. RACE: black	5. DATE OF BIRTH MONTH: 10 DAY: 11 YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: 5 MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	BALTO.	BALTO	YES ☒ NO ☐	120 William Wade Ave

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
UNKNOWN	ArThea Burrell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extreme prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5hrs.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7650

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/11, 19 88, to 10/11, 19 88, that (I) (we) last saw the deceased alive on 10/11, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Marilyn Sanders MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	10/11/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARILYN SANDERS	Francis Scott Key Med Ctr

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	10-14-88	FSKMC	Balt / Balt / MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FSKMC	4940 Eastern Ave	NOV 9 1988	Julia Davidson Registrar

BP.

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR: UNKNOWN 88-88

REG. NO. 88-38380

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST: UNKNOWN 88-88

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☐ — MONTH / DAY / YEAR: XX / 19 — **2b. HOUR**

3. SEX: MALE — **4. RACE**: 9 — **5. DATE OF BIRTH** MONTH / DAY / YEAR — **6. AGE** (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH / DAY / YEAR: 7-24-88 / 19 — **2d. HOUR**: 7:00 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore County — MD.

10. CITY OR TOWN OF DEATH: Woodlawn

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Stream behind Woodlawn Sr. High School

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE — **13b. COUNTY** — **13c. CITY OR TOWN** — **13d. INSIDE CITY LIMITS?** YES ☐ NO ☐ — **13e. STREET ADDRESS**: 00000

14. FATHER'S NAME FIRST / MIDDLE / LAST

15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) — (IF YES, GIVE WAR OR DATES) — **16b. SOCIAL SECURITY NO.**

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pending

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — **19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?** — **20. AUTOPSY?** YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — **21b. TIME OF INJURY** HOUR A.M. P.M. MONTH DAY YEAR 19 — **21c. HOW INJURY OCCURRED** (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **21e. PLACE OF INJURY** (AT HOME, STREET, FACTORY, FARM, ETC.) — **21f. LOCATION** STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes — TITLE (SPECIFY) M.D. Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED: 7-25-88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — **23b. DATE**: 7-11-89 — **23c. NAME OF CEMETERY OR CREMATORY** — **23d. LOCATION** CITY OR TOWN / COUNTY / STATE

24. FUNERAL DIRECTOR NAME / ADDRESS: State Anatomy Board, Balto., Md. 21201

25a. DATE REC'D. BY REGISTRAR: AUG 29 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VS 37. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

007371 SEP 16 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 88 38381

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
ETTA		CONEY	9	14	88 / 10:05 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Black	1 - 31 - 1917	71 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	U.S.A.		Balto. City MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Balto.	Lutheran Nursing Home Dukeland St.	Retired	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD		Balto.	YES ☒ NO ☐	2621 Loyola Southway 21215

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	A.	Williams	Georgia	Mae	Barnes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES / NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	219-22-5758	June Carroll	2621 Loyola Southway

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY — Approximate interval between onset and death:

DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA & DIABETIC FOOT ULCER

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) COAGULOPATHY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CVA, UGI BLEEDING, SEIZURE DISORDERS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/11 19 88, to 9/14 19 88, that (I) (we) last saw the deceased alive on 9/14 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
A.C. Chouvalit, M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	9/14/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A.C. CHOUVALIT	HOMEWOOD HOSPITAL CENTER

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
	9-17-88	King Memorial Park	Balto. County

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Irvin P. Carroll Funeral	1712-14 W. North Ave	SEP 15 1988	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR: Unknown 88-93

REG. NO. 88-38382

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	UNKNOWN 88-93
2a. DATE OF DEATH KNOWN ☐ OR ESTIMATED ☒ MONTH DAY YEAR	19
2b. HOUR	M
3. SEX	MALE
4. RACE	9
5. DATE OF BIRTH MONTH DAY YEAR	
6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
IF UNDER 1 YR. MONTHS DAYS	
IF UNDER 24 HRS. HOURS MIN.	
2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	7-31-1988
2d. HOUR	11:37 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
7b. CITIZEN OF WHAT COUNTRY?	
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Baltimore City 30 MD.
10. CITY OR TOWN OF DEATH	Baltimore
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	600 N. Howard Street
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	
13b. COUNTY	
13c. CITY OR TOWN	
13d. INSIDE CITY LIMITS? YES ☐ NO ☐	
13e. STREET ADDRESS	00000
14. FATHER'S NAME FIRST MIDDLE LAST	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
16b. (IF YES, GIVE WAR OR DATES)	
SOCIAL SECURITY NO.	
17. INFORMANT	
ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pending
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 8-1-88

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
Removal	7-11-89			

24. FUNERAL DIRECTOR NAME ADDRESS: State Anatomy Board, Balto., Md. 21201

25a. DATE REC'D. BY REGISTRAR: JUL 19 1989

25b. REGISTRAR'S SIGNATURE [signature]

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR UNKNOWN 88--171

REG. NO. 88-38383

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: UNKNOWN 88-171

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 11-29-88 | 2b. HOUR: M

3. SEX: MALE | 4. RACE: BLACK | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: 12-29-88 | 2d. HOUR: 1:18P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD

10. CITY OR TOWN OF DEATH: Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2511 Reisterstown Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS 00000

14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes
TITLE (SPECIFY) M.D. Acting Deputy Chief MEDICAL EXAMINER
DATE SIGNED 12-30-88

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal | 23b. DATE: 1-30-89 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: FEB 06 1989 | 25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 2. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

11846

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38384

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby · Boy MIDDLE: — LAST: Jackson	2a. DATE OF DEATH MONTH: 02 DAY: 13 YEAR: 88	2b. HOUR: 5 25 A.M.	
3. SEX: male	4. RACE: Black	5. DATE OF BIRTH MONTH: 02 DAY: 13 YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YEAR MONTHS: — DAYS: — IF UNDER 24 HRS. HOURS: 5 MIN.: 25
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD
10. CITY OR TOWN OF DEATH: Baltimore City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Liberty Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY

13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.		Baltimore	YES ☒ NO ☐	1533 N. Fulton Ave. 21217

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
	Joyce Jackson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Premature birth
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 02/13/19 88 to 02/13/19 88 that I (we) last saw the deceased alive on 02/13/19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
T. Ohiokpehai	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	3/7/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
T. Ohiokpehai, MD	Liberty Medical Center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
	JUL 7 '89	Julie Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

60462

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38385

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the personal data furnished by the funeral director, page 3 retained by the hospital or attending physician. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JUPITER	2a. DATE OF DEATH MONTH DAY YEAR	7- 26- 88	2b. HOUR	4:10 a.m.
3. SEX	MALE	4. RACE	BLACK	5. DATE OF BIRTH MONTH DAY YEAR	7 26 88
6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.			3 / 55
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	CHARLES MD.				
10. CITY OR TOWN OF DEATH	LaPLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PHYSICIANS MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Charles	Waldorf	YES ☐ NO ☐	4215 Quigley Ct. 20602

14. FATHER'S NAME (FIRST / MIDDLE / LAST)	15. MOTHER'S MAIDEN NAME (FIRST / MIDDLE / LAST)
DALE ANDRE JOHNSON	Carla Lavonne Jupiter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Premature rupture of membranes

DUE TO, OR AS A CONSEQUENCE OF (b) Premature labor

DUE TO, OR AS A CONSEQUENCE OF (c) _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Maria L. TanGatue delRosario	M.D.	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	4-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARIA L. TanGatue, delRosario, M.D.	P.O. Box 938 LaPlata, Maryland 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
	7/26/88	Hoop.	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Carl T. Potts	701 E. Charles St. LaPlata, Md.	MAY 7 '89	Julia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38386

1. DECEASED NAME (TYPE OR PRINT) — FIRST: AURORA | MIDDLE: DAWN | LAST: CHRISTIAN

2a. DATE OF DEATH — MONTH: 4 | DAY: 26 | YEAR: 88

2b. HOUR: 158 P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: 4 | DAY: 26 | YEAR: 88

6. AGE (IN YEARS LAST BIRTHDAY) — YRS

IF UNDER 1 YEAR — MONTHS | DAYS

IF UNDER 24 HRS. — HOURS | MIN. 1

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HOWARD MD.

10. CITY OR TOWN OF DEATH: Columbia

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Howard Co. Gen Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 00000

14. FATHER'S NAME — FIRST: Edward | MIDDLE: Joseph | LAST: CHRISTIAN JR

15. MOTHER'S MAIDEN NAME — FIRST: PATRICIA | MIDDLE: DIANE | LAST: CHRISTIAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Spontaneous Midtrimester Abortion

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. | MONTH | DAY | YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mary L. Clarke M.D.

DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION — CITY OR TOWN | COUNTY | STATE

24. FUNERAL DIRECTOR — NAME | ADDRESS

25a. DATE REC'D. BY REGISTRAR: JUN 22 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38387

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Jackson, Baby Boy.				2a. DATE OF DEATH MONTH / DAY / YEAR: 3/6/88		2b. HOUR: 1645 M
3. SEX: Male.	4. RACE: Black.	5. DATE OF BIRTH MONTH / DAY / YEAR: 3 / 6 / 1988		6. AGE (IN YEARS LAST BIRTHDAY): Fetus. YRS.	IF UNDER 1 YEAR: MONTHS 0 / DAYS 0	IF UNDER 24 HRS.: HOURS 2 / MIN. 40
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. N/A MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Mont.		MD.
10. CITY OR TOWN OF DEATH: Takoma Park, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A.	12b. KIND OF BUSINESS OR INDUSTRY: N/A.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: N/A	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS / ZIP CODE: 00000		
14. FATHER'S NAME FIRST / MIDDLE / LAST: George Jackson			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Carolyn Thomas Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A. (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: None	17. INFORMANT ADDRESS			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	NON-VIABLE FETUS	
DUE TO, OR AS A CONSEQUENCE OF (b)	FETUS WEIGHED 400GMS.	
DUE TO, OR AS A CONSEQUENCE OF (c)	EXTREME PREMATURITY	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3-6-, 19 88, to 3-6-, 19 88, that (I) (we) last saw the deceased alive on 3-6-, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: MDPandya	DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 3-6-1988
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MANGALA PANDYA, M.D.	22e. ADDRESS: 7445 Mahaska Drive, Derwood, MD 20855	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR: JUL 24 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Items18a htu 22a per M.E. Film

FOR 1- STATE REGISTRAR G651 5/23/89 CG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38388

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST: BABY	MIDDLE: BOY	LAST: MACK	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐: MONTH 9 DAY 1 YEAR 88	2b. HOUR
3. SEX: MALE	4. RACE: W.	5. DATE OF BIRTH: MONTH 9 DAY 1 YEAR 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 9 DAY 1 YEAR 88	2d. HOUR 7:13 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ Infant DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD	
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Adventist Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Mont.Co.	13c. CITY OR TOWN: Takama Pk.	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS: 6426 5th Avenue
14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST: Brenda MIDDLE: Lee LAST: Mack	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute chorioamnionitis
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH Unk. DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Unknown
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Unknown	21f. LOCATION STREET: Unknown CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 9/2/88

EXAMINER'S NAME (TYPE OR PRINT): Charles Kokes, M.D. ADDRESS: 111PennStreet,Balto.MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: 4-3-89	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Balto., Md.	25a. DATE REC'D. BY REGISTRAR: APR 22 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38389

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby Boy; LAST: WARE			2a. DATE OF DEATH: March 18 1988	2b. HOUR: 0915 AM
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH: MARCH 18 1988	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.	
10. CITY OR TOWN OF DEATH: TAKOMA PARK, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVENTIST HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
—	—	—	YES ☐ NO ☐	00000

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
DAVIS / — / CHARLES	ANNETTE / R. / WARE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT**	**ADDRESS**
NO	----	---------	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NON-VIABLE FETUS
DUE TO, OR AS A CONSEQUENCE OF (b) EXTREME PREMATURITY
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-18-, 1988, to 3-18-, 1988, that (I) (we) last saw the deceased alive on 3-18-, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M Pandya, MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	3-18-1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MANGALA PANDYA, M.D.	WASHINGTON ADVENTIST HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
—	—	—	—

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Not Known	JUL 24 1988	John Davidson-Kendall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 88-38390

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Foundling — MIDDLE — LAST: DOE
Unknown 88-142

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ — MONTH 11 DAY 11 YEAR 88 — 2b. HOUR

3. SEX: Male — 4. RACE: BLACK — 5. DATE OF BIRTH MONTH DAY YEAR: 11/11 1988 — 6. AGE (IN YEARS LAST BIRTHDAY): n/b YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD MONTH 11 DAY 11 YEAR 88 — 2d. HOUR 4:58P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Hyattsville — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Found: 5243 Kenilworth Avenue — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): n/a — 12b. KIND OF BUSINESS OR INDUSTRY: n/a

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: n/a — 13b. COUNTY: n/a — 13c. CITY OR TOWN: n/a — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: n/a

14. FATHER'S NAME — FIRST — MIDDLE — LAST

15. MOTHER'S MAIDEN NAME — FIRST: JANE — MIDDLE — LAST: DOE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. — 17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): External obstruction of airway
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 11-11-88 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject suffocated

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): la undry room — 21f. LOCATION STREET: 5243 Kenilworth Avenue, CITY OR TOWN: Hyattsville, COUNTY: Prince Georges County, MD STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐.

ACTUAL SIGNATURE: Julia C Goodin MD — TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER — DATE SIGNED 11/12/88

EXAMINER'S NAME (TYPE OR PRINT): Julia C. Goodin, M.D. — ADDRESS: 111Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — 23b. DATE: 4-10-89 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: State Anatomy Board, ADDRESS: Balto., Md. — 25a. DATE REC'D. BY REGISTRAR: MAY 4 1989 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

025636 MAY 27 89

FOR REGISTRAR UNKNOWN 88-152

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88-38391 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: UNKNOWN 88-152 MIDDLE: LAST: Doe

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 11-29-88 19

2b. HOUR: M

3. SEX: MALE

4. RACE: BLACK

5. DATE OF BIRTH MONTH DAY YEAR:

6. AGE (IN YEARS LAST BIRTHDAY) YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 11-29-88 19

2d. HOUR: 2:40P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY):

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD

10. CITY OR TOWN OF DEATH: Hyattsville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): woods-Carroll Highlands Elem.School

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS

14. FATHER'S NAME FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST: JANE MIDDLE LAST: Doe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thermal Burns
Conditions, if ony, which gave rise to immediate couse (a) stoting the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE: Charles P. Kokes

TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER

DATE SIGNED: 11-30-88

EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D.

ADDRESS: 111 Penn street, Baltimore, MD 21201

VC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 4-10-89

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME: State Anatomy Board, ADDRESS: Balto., Md.

25a. DATE REC'D. BY REGISTRAR: MAY 11 1989

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 88-38392

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Rachel	MIDDLE: ~~Warrington~~ Gaff	LAST: Pease	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐	MONTH	DAY	YEAR: 7-30-88	2b. HOUR	M
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: MONTH Feb.	DAY 22,	YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 7-30-	DAY / YEAR 1988	2d. HOUR: 9:35 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.						
10. CITY OR TOWN OF DEATH: Sharpsburg	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Route 1,Bx.316	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): doctor	12b. KIND OF BUSINESS OR INDUSTRY: medical						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Sharpsburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Route 1, Box 316 21782					
14. FATHER'S NAME FIRST: George	MIDDLE: H.	LAST: Warrington	15. MOTHER'S MAIDEN NAME FIRST: Elsie	MIDDLE	LAST: Holmes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 279-42-0662	17. INFORMANT ADDRESS: Mrs. Grace M. Cline, Williamsport, Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

1949

IMMEDIATE CAUSE (a) Pending

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐. BODY EXHUMED

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 4-20-89

VC EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Apr.21,1989	Rest Haven Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740	MAY 1 - '89	Richa Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEDGE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

502 07-84 25M BP

DHMH - 17 (VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR Late Cert. film G-654 reb

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

DUPLICATE
REG. NO. 88-38393

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: T.	LAST: Mack	2a. DATE OF DEATH MONTH: 06	DAY: 15	YEAR: 88
2b. HOUR: 2:24pM					
3. SEX: Male	4. RACE: B	5. DATE OF BIRTH MONTH: 03	DAY: 01	YEAR: 12	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City 30 MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET, ADDRESS): Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.		Baltimore	YES [ ] NO [ ]	1709 Presstman St. 21217

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph		Mack	Alice		Stewart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes		218-03-8434	Martha E. Day	1709 Presstman St. 21217

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Mesentery artery occlusion with gangrene	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
(1) Renal failure (2) COPD (3) ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/23 19 88 to 6/15 19 88, that (I) (we) last saw the deceased alive on 6/15 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Elmo Mayoso	M.D.	[ ] [✓] [ ]	6/16/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ELMO M. MAYOSO, M.D.	5411 Old Frederick Road, Baltimore, MD 21229

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial		Garrison Forest	Owings Mills, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James A. Morton & Sons 1701 Laurens St.	AUG 29 1989	Julia Davidson-Randall

012925 NOV 14 88 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88-38394

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: John	Middle: B.	Last: DESCH	2a. DATE OF DEATH Month: 11	Day: 1	Year: 88
2b. HOUR: 11 15 PM					
3 SEX: male	4 RACE: C	5 DATE OF BIRTH Month: 02 Day: 20 Year: 08	6 AGE (IN YEARS LAST BIRTHDAY): 80 YRS	If under 1 year: Months / Days	If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH: ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ANNE ARUNDEL GEN. HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: AA Co	13c. CITY OR TOWN: Annapolis	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 136 Spaview Ave	
14. FATHER'S NAME First: FERDINAND Middle: C. Last: DESCH	15. MOTHER'S MAIDEN NAME First: SARAH Middle: NA Last:				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NA	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 320-10-9158	17. INFORMANT ADDRESS: Nancy Lecourt-136 Spaview Ave. Annapolis, Md. 21401		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Upper Gastrointestinal Bleeding

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) 5 MINUTES (b) 2 DAYS (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/1 19 88 to 11/1 19 88, that (I) (we) last saw the deceased alive on 11/1 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Scott Eden	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11/1/88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT SCOTT EDEN	22e. ADDRESS: 703 GIDDINGS AVE. ANNAPOLIS, MD 21401		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: 11-2-88	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: State Anatomy Board ADDRESS: Balto., Md.	25a. DATE REC'D. BY REGISTRAR: NOV 07 1988	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP ____

DHMH - 16 50M 1/81 (VRA 15, 4)

013290 NOV 16 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38395

1. DECEASED NAME (TYPE OR PRINT) FIRST: Evette	MIDDLE: BG	LAST: Knight	2a. DATE OF DEATH MONTH: 10 DAY: 19 YEAR: 88	2b. HOUR: 3 15 M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS: 8 MIN.: 15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto. MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balto. City 30 MD.		
10. CITY OR TOWN OF DEATH: Balto. MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key Med Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY	13c. CITY OR TOWN: BALTO	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS / ZIP CODE: 4013 Norfolk Ave 21216	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST: Evette MIDDLE LAST: Knight			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: 4013 Norfolk Ave Balto. MD 21216		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Severe Immaturity - 20 wks GA	
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): F. EYAL	22e. ADDRESS: FSK 4940 Eastern Ave. Baltimore	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation	23b. DATE: 10-21-88	23c. NAME OF CEMETERY OR CREMATORY: FSKMC	23d. LOCATION CITY OR TOWN: Balt COUNTY: Balt STATE: MD	
24. FUNERAL DIRECTOR NAME AND ADDRESS: FSKMC 4940 Eastern Ave Balt MD 21224	25a. DATE RCVD. BY REGISTRAR: NOV 20 1988	25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38396

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST: UNKNOWN #88-37 -- BABY JANE DOE

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH / DAY / YEAR: March 1988

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH / DAY / YEAR:

6. AGE (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN:

2c. DATE PRONOUNCED DEAD — MONTH / DAY / YEAR: 3--27-- 1988

2d. HOUR: 7:10 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY):

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore County 03 MD.

10. CITY OR TOWN OF DEATH: White Marsh

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): New Forge Rd. off Philadelphia Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Unk.

13b. COUNTY:

13c. CITY OR TOWN:

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: Unk. 99999

14. FATHER'S NAME — FIRST / MIDDLE / LAST: Unknown

15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST: Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Exposure

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: Found 3--27--- 1988

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Found in plastic bag on an embankment.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Roadway embankment

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE: New Forge Rd. off Philadelphia Rd., White Marsh, Balto. MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE: John E. Smialek M.D.

TITLE (SPECIFY): Chief MEDICAL EXAMINER

DATE SIGNED: 4--25--88

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D.

ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY):

23b. DATE:

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION — CITY OR TOWN / COUNTY / STATE:

24. FUNERAL DIRECTOR — NAME / ADDRESS:

25a. DATE REC'D. BY REGISTRAR: MAY 3 1988

25b. REGISTRAR'S SIGNATURE: Lisa Tenderson-Landers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE FUNERAL DIRECTOR SHOULD CONTACT THE MEDICAL EXAMINER TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 88-38397

1. DECEASED NAME (TYPE OR PRINT): First Philip Middle E. Last Fordham
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month 12 Day 14 Year 1988
2b. HOUR M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: Month 12 Day 13 Year 1963
6. AGE (IN YEARS LAST BIRTHDAY): 25 YRS.
IF UNDER 1 YR. Months Days; IF UNDER 24 HRS. Hours Min.
2c. DATE PRONOUNCED DEAD: Month 12 Day 14 Year 88
2d. HOUR 8:00A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey
7b. CITIZEN OF WHAT COUNTRY? U S
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline County MD.
10. CITY OR TOWN OF DEATH: Hartly
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Maryland/Delaware border
12a. USUAL OCCUPATION (TYPE OF WORK): Carpenter
12b. KIND OF BUSINESS OR INDUSTRY: Lumber

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Del.
13b. COUNTY: Kent
13c. CITY OR TOWN: Hartly
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Rd 1 Box 268 C

14. FATHER'S NAME: First Bernard P. Middle Last Fordham
15. MOTHER'S MAIDEN NAME: First Virginia Middle Fordham Last Mickerson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. SOCIAL SECURITY NO.: 221-62-6696
17. INFORMANT: Virginia Mickerson ADDRESS: Rd1 Box 268 C Hartly, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS: UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY: HOUR A.M. 7:00AM Month 12 Day 14 Year 88
21c. HOW INJURY occurred (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Driver in auto/overturned in a ~~pond~~ pond
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): water
21f. LOCATION: STREET Maryland/Delaware border CITY OR TOWN CAROLINE COUNTY COUNTY STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.
ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Chief MEDICAL EXAMINER DATE SIGNED: 12-15-88
EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-17-88
23c. NAME OF CEMETERY OR CREMATORY: Sharon Hill
23d. LOCATION CITY OR TOWN: Dover COUNTY: Kent STATE: Del.
24. FUNERAL DIRECTOR NAME: Thomas F. Traden ADDRESS: 12 Lotus ST 19901 Dover, DELAWARE
25a. DATE REC'D BY REGISTRAR: DEC 20 1988
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as required by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH 16 50M 1/81 (VRA 15, 4)

BP

Autopsy from Co. H.D. 8/31/90 Kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38398

HOPE | MAY 17, 1988 | 8:20

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81
(VRA 15, 4)

HOLLOWAY FUNERAL HOME

MAY 20 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

88-5440

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38399

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Autry	2a. DATE OF DEATH MONTH DAY YEAR: 10/7/88	2b. HOUR: 2A M			
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 10 6 88	6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS.	IF UNDER 1 YEAR MONTHS / DAYS:	IF UNDER 24 HRS. HOURS: 6 MIN.: 20
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto MD USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balt City MD.		
10. CITY OR TOWN OF DEATH: Balt City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FSKMC	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY: N/A		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.		Balto..	YES ☑ NO ☐	324 E. 27th Street

14. FATHER'S NAME (FIRST / MIDDLE / LAST)	15. MOTHER'S MAIDEN NAME (FIRST / MIDDLE / LAST)
	Malinda L. Autry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A	N/A	N/A	Birth Certif.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	22c. DATE SIGNED
Alexander Adams Jr. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Alexander Adams Jr.	Baylis Scott Rehabilitation Center

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
cremation	10-10-88	FSKMC	Balt Baltimore Md

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FSKMC 4940 Eastern Ave Balt. Md 21224		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

РРЕРС-28

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Свободен вибег

Свободен вибег

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STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-3840

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)	FIRST Anastasia (Baby Girl)	MIDDLE Alexandria	LAST HASKINS	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 7:45 PM
	Caterina			10 1 88	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
FEMALE	BLACK	10 1 88	YRS		10
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	FRANKLIN SCOTT KEY MedCtr				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.		Balto.	YES ☒ NO ☐	2448 Eutaw Street

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Alfred	Alexander	Nance	Walaika	Kamyma	HASKINS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			birth certif.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	10 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	HYALINE MEMBRANE DISEASE	"
DUE TO, OR AS A CONSEQUENCE OF (c)	EXTREME PREMATURITY	"

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☑ NO ☐	YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/1, 19 88, to 10/1, 19 88, that (I) (we) last saw the deceased alive on 10/1, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Charles R. Hamm Jr	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	10/1/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHARLES R. Hamm JR	4940 Eastern AVE BALT. MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	
cremation	10/3/88	FSKMC	Balt.	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FSKMC	4940 Eastern Ave. Balt. MD 21224	OCT 07 1988	Julia Davidson-Randall

88-384

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OCT 07 1988

011850 NOV 3 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38401

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file pages 1 and 2 with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. Page 4 may be

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby Boy	MIDDLE	LAST: LAWRENCE	2a. DATE OF DEATH MONTH: 10	DAY: 4	YEAR: 88	2b. HOUR: 5:15 PM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: 10	DAY: 4	YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR MONTHS / DAYS: 4 HOURS / MIN.	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED XX ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: CITY MD.				
10. CITY OR TOWN OF DEATH: BALT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FRANCIS SCOTT KEY	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY	13c. CITY OR TOWN: Balto.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 423 N. Patterson Pk. Ave.			
14. FATHER'S NAME FIRST	MIDDLE: UNK.	LAST	15. MOTHER'S MAIDEN NAME FIRST: Camilla	MIDDLE	LAST: Lawrence		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: none	17. INFORMANT: birth certif.	ADDRESS			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): EXTREME PREMATURITY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles R. Hamm Jr — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/4/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES R. HAMM JR — 22e. ADDRESS: 4940 EASTERN AVE, BALT 21224

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation	23b. DATE: 10-7-88	23c. NAME OF CEMETERY OR CREMATORY: FSKMC	23d. LOCATION CITY OR TOWN: Balt	COUNTY: Balt	STATE: Md.
24. FUNERAL DIRECTOR NAME: FSKMC	ADDRESS: 4940 Eastern Ave Balt. MD 21224	25a. [illegible] OCT 17 [illegible]	25c. REGISTRAR'S SIGNATURE: Patricia Anderson Randall		

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

UNCONTROLLED COPY

0103866 Cert # 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38402

1 - STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): FIRST Natalie MIDDLE Barton LAST ~~Mart BG~~ Muirhead
2a. DATE OF DEATH: MONTH 10 DAY 15 YEAR 88
2b. HOUR: 4:45 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 10 DAY 5 YEAR 88
6. AGE (IN YEARS LAST BIRTHDAY): YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS 1 MIN. 57
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Balto. City MD
10. CITY OR TOWN OF DEATH: Balto
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key Med Ctr.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Howard
13c. CITY OR TOWN: ~~City~~ Lusby
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: P.O. Box 402

14. FATHER'S NAME: FIRST Alfred MIDDLE Barton LAST Muirhead
15. MOTHER'S MAIDEN NAME: FIRST MARI MIDDLE Lynette LAST MUIRHEAD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): none (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: n/a
17. INFORMANT ADDRESS: Birth certif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Treatable Fetus
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES R Hamm Jr
22e. ADDRESS: 4940 EASTERN AVE

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation
23b. DATE: 10-7-88
23c. NAME OF CEMETERY OR CREMATORY: FSKMC
23d. LOCATION CITY OR TOWN: Balt. COUNTY: Balt STATE: Md

24. FUNERAL DIRECTOR NAME: FSKMC 4940 Eastern Ave ADDRESS: Balt., Md 21224
25a. DATE REC'D. BY REGISTRAR: OCT 17 1988
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-19403

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby Boy MIDDLE: Sandra LAST: Rice		2a. DATE OF DEATH MONTH DAY YEAR: 10. 5. 88	2b. HOUR: 2:20 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 4 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS: IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS. HOURS: 3 MIN.: 5
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Balto. City MD.
10. CITY OR TOWN OF DEATH: Balto City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frances Scott Key Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.		Balto.	YES ☒ NO ☐	868 W. Lombard St.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
unknown	Sandra M. Rice

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
no			Birth certif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Therapeutic Abortion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3hrs 5 min

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 10. 4. 88 19 88, to 10 - 5 19 88, that (I) (we) last saw the deceased alive on 10. 5. 88 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	22c. DATE SIGNED
Marilyn Sand MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	10.5.88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARILYN SANDERS	Francis Scott Key

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
cremation	10-7-88	FSKMC	Balt. Balt. MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FSKMC	1940 Eastern Ave	Balt, MD 21224	OCT 17 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The blank lines on carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, [illegible] medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

EOP86-99

Y1

20% COTTON FIBER

WHITE

WHITE

WHITE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-354.24

1. DECEASED NAME (TYPE OR PRINT) FIRST: B/B	MIDDLE: TWIN A	LAST: WHITAKER	2a. DATE OF DEATH MONTH: 10	DAY: 9	YEAR: 88	2b. HOUR: 1125 AM	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: 10	DAY: 8	YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY): — YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS: 11	MIN.: 35
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BALTIMORE	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY			MD.	
10. CITY OR TOWN OF DEATH: BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FRANCIS SCOTT KEY HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
N.C.		Enfield	YES ☐ NO ☒	502 Bell Street

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Unknown			MARIA	Leigh	WHITAKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		n/a	Birth certif.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EXTREME PREMATURITY
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMOPERICARDIUM
DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE RESPIRATORY DISTRESS SIND.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
		—

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	—	—			

22a. I certify that (I) (this hospital) attended the deceased from 10-7, 19 88, to 10-9, 19 88, that (I) (we) last saw the deceased alive on 10-9, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10-9-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
E. CANTAVA	4940 Eastern Ave

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
cremation	10-11-88	FSKMC	Balt	Balt	Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FSKMC	4940 Eastern Ave Balt. Md. 21224	OCT 17 1988	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

N/K

88-55325

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

88-3640-1

013288 NOV 16 88

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 88-38405

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	WRIGHT BABY BOY			2a. DATE OF DEATH MONTH DAY YEAR	10/31/88
				2b. HOUR	9:45 AM
3. SEX	M	4. RACE	BLACK	5. DATE OF BIRTH MONTH DAY YEAR	10/21/88
6. AGE (IN YEARS LAST BIRTHDAY)	YRS	IF UNDER 1 YEAR MONTHS	10	DAYS	IF UNDER 24 HRS HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	BALTO MD	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	BALTIMORE COUNTY MD				
10. CITY OR TOWN OF DEATH	BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	GBMC	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Newborn
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD		Baltimore	YES ☒ NO ☐	5616 Ready Ave

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	(NMN)	Sanders	Cynthia	(NMN)	Wright

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
N/A			MOTHER	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF

(b) SEVERE BLEEDING DIATHESIS

DUE TO, OR AS A CONSEQUENCE OF

(c) HYALINEMEMBRANE DISEASE SEPSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from OCT 21 19 88 to OCT 31 19 88 that (I) (we) last saw the deceased alive on OCT 31 19 88 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/31/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR AMBADAS PATHAK	6701 N CHARLES ST 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
	NOV 14 1988	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 88-38406

1. DECEASED NAME (TYPE OR PRINT): FIRST Harry / MIDDLE B / LAST Ford

2a. DATE OF DEATH: MONTH 2 / DAY 26 / YEAR 88 — 2b. HOUR 2110 M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH November / DAY 22 / YEAR 1919

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MINS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery County MD.

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Shady Grove Adventist Hospital 5GAH Rockville, Md

12a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE): (Retired) Dep't of Navy

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Rockville — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 711 Beall Avenue 20850

14. FATHER'S NAME: FIRST Albert / MIDDLE / LAST Ford

15. MOTHER'S MAIDEN NAME: FIRST Mary / MIDDLE V. / LAST Barrett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 578-16-8186A

17. INFORMANT: Mary P. Ford (wife) ADDRESS: 711 Beall Avenue Rockville, Maryland 20850

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ≈2½ HRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Anterior Wall Myocardial Infarction 7 days
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES [ ] NO [X] — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from 26 Feb 19 88 to 26 Feb 19 88, that (I)(we) last saw the deceased alive on 26 Feb 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD (DR SAURI) — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 26 Feb 88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL A. SAURI, MD — 22e. ADDRESS: 9715 Med Ctr DR #201, Rockville, Md 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 3/2/88 — 23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery — 23d. LOCATION CITY OR TOWN: Silver Spring, COUNTY: Maryland STATE

24. FUNERAL DIRECTOR NAME: Tyson Wheeler Funeral Home, Inc. ADDRESS: 1331 Rockville Pike Rockville, Maryland 20852

25a. DATE REC'D. BY REGISTRAR: MAR 07 1988 — 25b. REGISTRAR'S SIGNATURE: [signature]

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS: 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

MAR 07 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38407

1a FOR STATE REGISTRAR per hosp 4/14/92 kam FilmG686

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jason	MIDDLE: Dean	LAST: Cole	2a. DATE OF DEATH MONTH DAY YEAR: March 20, 1988	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 3 20 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.: 20
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ infant	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): South Balto. Gen. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): infant	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.	13b. COUNTY: A.A.	13c. CITY OR TOWN: Pasadena	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 8545 Summit Road

14. FATHER'S NAME FIRST / MIDDLE / LAST: timothy / John / Cole	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Regina / Mary / Cole	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: hosp/b.C. 4/14/92 kam

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): unknown
DUE TO, OR AS A CONSEQUENCE OF
(b): prematurity
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Valerie Lasry	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 4/6/92
22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. Lasry	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): removal	23b. DATE: 3/20/88	23c. NAME OF CEMETERY OR CREMATORY: So. Balto. Gen.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto., Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECEIVED BY REGISTRAR: APR 14 92	25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE OFFICE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

88-38408

REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nora	MIDDLE: Mary	LAST: [redacted]OEHM	2a. DATE OF DEATH MONTH: 03	DAY: 09	YEAR: 88	2b. HOUR: 8:20a M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 02	DAY: 09	YEAR: 06	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore County MD.			
10. CITY OR TOWN OF DEATH: Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Baltimore Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesperson	12b. KIND OF BUSINESS OR INDUSTRY: Retail Sales			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	21239	Baltimore	YES [ ] NO [ ]	1700 Meridene Drive 21239

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Kenney	Davis	Nora	Lucy	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	------	216-01-8269	Christy Oehm 1700 Meridene Dr. 21239

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chronic Obstructive Pulmonary Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	3/9/88

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Anthony Serafis, M.D.	G.B.M.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	MAR. 11, '88	PARKWOOD CEMETERY	BALTIMORE CO., MD

24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
WILLIAM E. JOHNSON 8521 [illegible] RAVEN BLVD.	MAR 10 1988	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA T5, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 88-38409

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: ADAMS			2a. DATE OF DEATH MONTH DAY YEAR: Oct. 20, 1988	2b. HOUR: 9:10P M
A 3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 10 20 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS. / IF UNDER 1 YEAR MONTHS DAYS / IF UNDER 24 HRS. HOURS MIN.: 3 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.	
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Francis Scott Key Med. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): infant	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS
14. FATHER'S NAME FIRST / MIDDLE / LAST			15. MOTHER'S MAIDEN NAME FIRST: Brenda / MIDDLE / LAST: ADAMS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no / (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: none	17. INFORMANT ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Extreme Immaturity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: F. Egol M.D	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 6-20-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ~~F. Egol~~, M.D.	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY: FSKMC	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto., Md.
24. FUNERAL DIRECTOR NAME: None / ADDRESS		25a. DATE REC'D BY REGISTRAR: JUN 7 '90	25b. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

#1,FilmG668 10/1/90 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38410

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Baby MIDDLE: Boy LAST: HALL, Arroyo Kenneth John A	2a. DATE OF DEATH MONTH DAY YEAR: 6-6-88	2b. HOUR: 1:30 PM	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: 6 6 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YEAR MONTHS — DAYS — IF UNDER 24 HRS HOURS 1 MIN. 21
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTO CITY MD.
10. CITY OR TOWN OF DEATH: Baltimor	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SINAI	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: —	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET ADDRESS: 4 Randall Field Ct. 00000			
14. FATHER'S NAME FIRST: Jose' MIDDLE: ANTONIO LAST: ARROYO	15. MOTHER'S MAIDEN NAME FIRST: Eileen MIDDLE: MARIE LAST: HALL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): — (IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: —	17. INFORMANT ADDRESS: —	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Premature

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 765.1

DUE TO, OR AS A CONSEQUENCE OF (b): —

DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): —	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): —	21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —	

22a. I certify that (I) (this hospital) attended the deceased from JUNE 6, 19 88, to JUNE 6, 19 88, that (I) (we) last saw the deceased alive on JUNE 6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ron C. Buckley	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 06/26/90
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ron C. Buckley MD	22e. ADDRESS: Sinai Hospital of Baltimore		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): —	23b. DATE: —	23c. NAME OF CEMETERY OR CREMATORY: Sinai Hospital	23d. LOCATION CITY OR TOWN — COUNTY — STATE —	
24. FUNERAL DIRECTOR NAME — ADDRESS —		25a. DATE REC'D. BY REGISTRAR: JUL 02 1990	25b. REGISTRAR'S SIGNATURE: Julie Reardon-Pendergast	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

#1, FilmG668 10/1/90 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38411

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

1. DECEASED NAME (TYPE OR PRINT) FIRST: ~~Baby Girl~~ Lauren MIDDLE: Patricia LAST: Hall, Arroyo B				2a. DATE OF DEATH MONTH: 6 DAY: 6 YEAR: 88	2b. HOUR: 1:30 PM
3. SEX: Female	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH: 6 DAY: 6 YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS: 1 / MIN.: 13
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTO City MD.		
10. CITY OR TOWN OF DEATH: Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SINAI	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: —	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 4 Randall Field Court 00000	
14. FATHER'S NAME FIRST: José MIDDLE: ANTONIO LAST: ARROYO		15. MOTHER'S MAIDEN NAME FIRST: Eileen MIDDLE: MARIE LAST: HALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): —	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: —	17. INFORMANT ADDRESS		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
7651
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JUNE 6, 19 88, to JUNE 6, 19 88, that (I) (we) last saw the deceased alive on JUNE 6 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas G. Scully	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 6/26/90
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas G. Scully, MD	22e. ADDRESS: Sinai Hospital of Baltimore		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: Sinai Hospital	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR: JUL 02 1990	25b. REGISTRAR'S SIGNATURE: [illegible]	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

076430 MAY - 4 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-38412

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: RICHARD	Middle: T.	Last: FREDMAN, JR.	2a. DATE OF DEATH Month Day Year: April 19, 1988	2b. HOUR: 9:40 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: July 21, 1926	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Car Foreman	12b. KIND OF BUSINESS OR INDUSTRY: Railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES [X] NO [ ]	803 Winifred Road/ 21502

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Richard T. Fredman, Sr.	Ruth Reed

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		213-22-2611	Mrs. Ruth D. Fredman - same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY ARREST	immed.
DUE TO, OR AS A CONSEQUENCE OF (b)	pneumonia	3wks
DUE TO, OR AS A CONSEQUENCE OF (c)	Chronic Bronchitis + Emphysema	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
[ ]		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 3/6, 19 88, to 4/19, 19 88, that (I) (we) last saw the deceased alive on 3/17, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark Sey	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. James Raver	Memorial Hospital Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Apr. 22, 1988	Branch Mtn. Bap.	Three Churches, Hampshire, W VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr. LaVale, MD 21502	APR 25 1988	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 88-3843

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: VINCENT / FERRARA, SR.			2a. DATE OF DEATH MONTH DAY YEAR: 5 20 88	2b. HOUR: 750 A M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 27, 1913	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH: BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Stone Mason	12b. KIND OF BUSINESS OR INDUSTRY: Construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: --	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 4616 Clareway, 21213
14. FATHER'S NAME FIRST / MIDDLE / LAST: Rosario Ferrara			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Rose Bondino	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 217-09-8250	17. INFORMANT ADDRESS: Mary G. Ferrara, Wife, Same as above	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): probable acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: emphysema, malnutrition

19a. DATE OF OPERATION: 5-19-88	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: benign prostatic hypertrophy	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from [illegible] 19 88, to May 20 19 88, that (I) (we) last saw the deceased alive on 5/20 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Patrick G. O'Daniel	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 5-20-88
22d. PHYSICIAN'S NAME (TYPE OR PRINT): PATRICK O'DANIEL, M.D.	22e. ADDRESS: UNION MEMORIAL HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 5/21/88	23c. NAME OF CEMETERY OR CREMATORY: Security Process	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Balto, Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto, Md. 21213		25a. DATE REC'D. BY REGISTRAR: MAY 24 1988	25b. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 21 per DVR G926 4/12/12 dk

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

Certificate of Death

Reg. No. 1988-38414

Physician/ Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Gloria Jean Nesbitt	July 1 1988	12:15 A M

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1008 Gorsuch Garth	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
206-38-9469	1 ☐ M 2 ☒ F	41 Yrs.			9/7/1946	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Bel Air	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1008 Gorsuch Garth	21014	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
unk		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Marvin Lee Via	Lottie Virginia Garrison

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
David V. Nesbitt	1008 Gorsuch Garth, Bel Air MD 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Churchville Cem.	7/7/1988	Oberlin, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Howard K. McComas III	McComas Funeral Home, Abingdon MD 21009

Physician/ Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Breast Carcinoma	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☐ No 9 ☒ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ **Certifying Nurse Practitioner:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dr Davis M. Hahn	D20396	4/12/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Davis M. Hahn, 5601 Loch Raven Blvd., Ste. 103, Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 12 2012	Donna B. Sparks

DHMH 17 Rev 06-2011

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit